A study to explore the current and potential relevance and value of case management to community nursing

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Abstract

The term "case management" came into sharp focus in the UK following the community care policy of the early 1990s, together with subsequent guidance. However, despite an apparent compatibility with community nursing values, there appear to be few detailed studies focusing on the issues surrounding community nurses assuming the role.

The aim of this study was to go some way toward filling this gap in the research by exploring:

- the extent and nature of community nursing involvement in case management.
- the main features of case management projects which included community nurses.
- how these variables related to perceptions of community nurse case management of those involved.
- the "durability" of case management as a model for community nursing.

The research consisted of four phases. An initial telephone survey of all (then) Health Authorities in England, followed by a more detailed questionnaire of those implementing case management-like practices sought to address the first two objectives. The third phase comprised a purposeful sample of 13 cases (selected from questionnaire responses) for more in-depth study through interviews and examination of related documentation, and aiming to account for why particular practices did, or did not, work at case level. Finally, a longitudinal follow-up questionnaire was sent to all original questionnaire and case respondents after 4-5 years, which sought to address the last objective.

Data from 122 questionnaire responses, the literature and descriptive case analyses were used to construct a set of propositions as a basis for a pattern-matching, thematic case analysis. Findings supported an overall, sustainable compatibility between case management and community nursing, with "best" practices being identified along a

number of parameters. The method facilitated the construction of a conceptual model outlining the interrelated impact on community nursing case management of four types of contextual variables, which may help to guide future professional practice.

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1. Literature review

1.1 Introduction

1.1.1 Overview of subject area

The term case (or care) management achieved an international currency over a remarkably short time span. As a practice issue, it is generally thought to have its roots in North American mental and social casework of the 1970s and 1980s, conceived as a means of addressing problems of service fragmentation and cost containment in long-term care (Beardshaw and Towell 1990, Cohen & Cesta 1993). However, the North American literature emanating from subsequent case management projects suggests that this organisational framework for care has had varying degrees of success in achieving these aims across their diverse settings and client groups (Kemper et al 1987, Worley 1991a).

From the late 1980s the issue began to achieve similar prominence in the United Kingdom (UK). The explanation for this is undoubtedly multifactorial, and not unconnected to this North American heritage. Indeed, the patterns of care which ostensibly precipitated case management initiatives in North America were recognised by critics of the British scene as being replicated here - paternalistic, service-led provision, inflexibility, service duplication and gaps - with the implicit corollary that solutions will be likely to follow on similar lines (Beardshaw and Towell, 1990).

In addition, UK policy makers in the 1990s embraced case management as relevant in its own right to the national scenario. The history of, and predicted, increase in the numbers of dependent people in the community (Office of Population Censuses and Surveys [OPCS], 1988), combined with the promotion of policies encouraging deinstitutionalisation for certain long-term client groups (Askham and Thompson 1990, Richardson and Higgins 1990) meant that cost-effective, well integrated community care schemes were being sought to meet those challenges; case management, as in the instances cited, was considered as one way forward. But it was

perhaps with the publication of the White Paper "Caring for People" (Department of Health [DoH], 1989a) that the term case management became indelibly stamped on the public, and professional, consciousness with the Government pledge, *inter alia*, "to make proper assessment and good case management the cornerstone of high quality care" (para. 1.11).

Only more recently has case management been the focus of dedicated research, particularly at its interface with community nursing. This may be considered surprising when, as far back as 1990, the Queen's Nursing Institute argued that the postponement of the implementation of the community care reforms, following the NHS and Community Care Act of that year, should have been seen as providing policy makers and researchers with an opportunity to review existing schemes in order to inform future provision (Queen's Nursing Institute, [QNI]1990).

It must be acknowledged that research has incrementally (if slowly) taken place, but early work appears to have been largely influenced by incentives to pursue the Government's social service dominated model and this can be instanced by the (then) DHSS funded Care in the Community projects (Cambridge, 1990) and the pioneering studies undertaken by the Personal Social Services Research Unit [PSSRU] (Challis & Davies 1986, Challis et al 1990), which themselves explicitly influenced policy. Indeed, it may be argued that these studies are not without considerable value in exploring the potential of international perspectives and national policies to influence UK case management practices. However, evidence of community nursing involvement in such projects has often been marginal (for example Challis et al 1990, Archer and Robertson 1990) and work conducted by, and focused upon, nurses and nursing was slow to develop (Ross and Tissier, 1996). Moreover, the lack of emphasis on case management in the health and social policy announced by the new Labour Government in 1997 (DoH, 1997) prompts further questioning regarding its suitability as a model for community nurses. It is hoped that the current study will go some way to supplementing this body of work.

1.1.2 Aims, parameters and structure of the review

Mindful of the intended focus of the study, that is, the compatibility between case management and community nursing as models of care, the review aims were identified in the form of questions covering four main areas covered in the literature:

1) In what ways have contextual variables shaped case management practices in the UK and how have these affected community nursing?

[Rationale/assumptions: The broad international and national social policy background is a necessary (though not sufficient) determinant of not only care practices, but also their supporting ideals. This background therefore needs to be examined as it is interwoven into the very substance of both case management and community nursing; without understanding their mutual frame of being, it is difficult to know how these areas might relate.]

2) How far are the philosophies underpinning case management compatible with the values inherent in the health and social care professions, particularly community nursing?

[Rationale/assumptions: Evidence in answer to this question will give an indication of the likelihood (and appropriateness) of the one assimilating into its practices the values of the other.]

3) What evidence is there of the effectiveness of case management as a means of caring for people in the community in the UK?

[Rationale/assumptions: Without some indication that case management is of benefit, it is unlikely that it will have any potential relevance or value to community nursing.]

4) To what extent does UK practice suggest community nurses are appropriate case managers and what issues need to be addressed in this area?

[Rationale/assumptions: This question is the heart of the issue and directly seeks information which the preceding questions can only provide by extrapolation. The degree and nature of the evidence here will inform any subsequent research.]

The four main areas highlighted above dictated the type of literature to be examined, which falls into four corresponding groups. Within each group, material was accessed through a different method. Because of the relative recency of the topic at the start of the investigation, and following an initial search, it was not thought useful to explore further computer databases, which would only cite published work.

1) Background literature. This was subdivided into two areas:
i) Largely descriptive and minimally analytic literature from North America. This mainly consisted of journal articles and some texts from the 1980s providing accounts of examples of case management in different care settings by various professionals, including nurses. This literature was traced mainly through secondary referencing in related papers of both American and British origin.

ii) UK policy documents, official guidance and monitoring exercises, together with commentaries and early evaluations on these directed at particular issues. This literature dated from the immediate antecedents of the White Paper "Caring for People" (DoH, 1989a) and was concentrated around the early 1990s, with a tailing off following the 1997 change of Government. Material was accessed in the main as it appeared. Some official publications were less well publicised and were acquired retrospectively.

2) Professional (especially community nursing) based literature. This was of three types:

i) General nursing and related literature exploring characteristics of, and developments in, professionalism within the caring disciplines, where these may interlink with case management.

ii) Nursing literature from inside and outside the UK describing existing relationships between case management, related concepts and nursing.

iii) Largely anticipatory/conjectural work appearing in UK professional journals in the wake of publication of the proposed community care reforms, which focused on the exploration of the anticipated role of care professionals within the new framework. This area largely comprised opportunistic literature, and was necessarily selective, since its publication was prolific and quality variable.

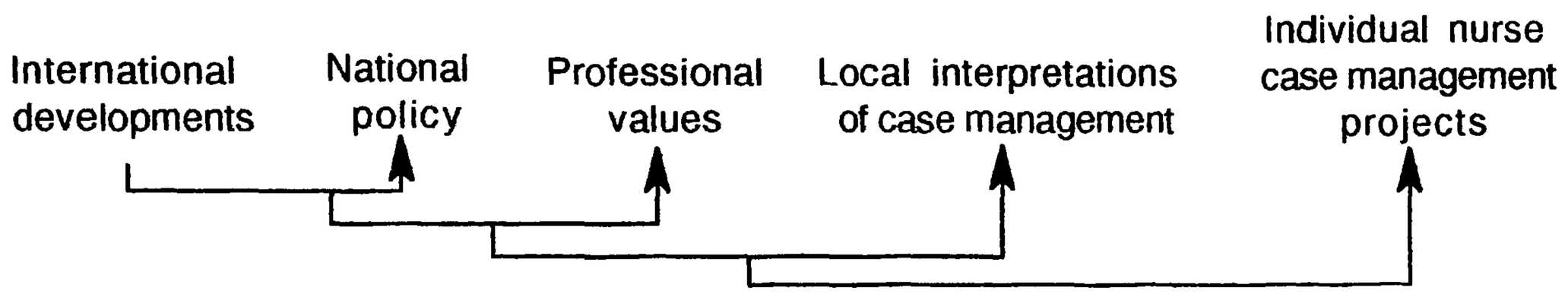
3) Evidence from UK case management research projects, together with literature discussing issues related to researching case management generally. A growing body of work, from 1986 onwards became available, increasing in comprehensiveness and sophistication. This consisted mainly of large, funded, time limited projects based in either multidisciplinary or social service settings. This literature was not readily available and early interim reports/monographs often necessitated approaching the researchers themselves, who provided the material. Later, final published reports often appeared which were, inevitably, more easily accessible.

4) Evidence from community nurse case management projects and case management research with a nurse author or perspective. This often concerned a single nurse case manager within a multidisciplinary team and examples where the nursing role was explored in depth were uncommon. These were generally the most difficult to access. Short references in professional journals often failed to provide details of source and attempts to trace authors by place of project (where detailed) were often unsuccessful. Occasional papers were found in academic nursing journals, or,

where nursing formed part of a larger, multidisciplinary effort, in other health care publications.

The review structure is based on the areas identified above, which progress from the general to the focused. In addition, the logic of the sequencing suggests a cumulative nature which may be ascribed to the evidence; in other words it could be argued that the answers to any question concerning the compatibility between case management and community nursing will be based on the cumulative effects of the variables addressed in the different sections (fig.1.1)

Fig. 1.1 Structure of the review: main areas impacting on the questions posed of the literature.



1.1.3 Theoretical and operational definitions and models.

It is probably no exaggeration to suggest that there are as many definitions of case management as there are case management projects extant. Indeed, commentators have seen the very substance of an ideology within this diversity, the creed of which is based on developing approaches to care reflective of local needs and contexts (Beardshaw 1991, Knapp et al 1992, Lee et al 1998). However, a number of commonalities may be identified wherever case management is seen to operate, and these may be broadly encapsulated in the definition offered by Onyett:

> "Case management is a way of tailoring help to meet individual need through placing responsibility for assessment and service co-ordination with one individual worker or team" (Onyett, 1992, p.3).

This generic description is derived from the North American origin of case management, with its stress on co-ordination as a counter to the service fragmentation and spiralling health care costs already cited. The oft-quoted, if now rather dated, definition of Intagliata (1982), for instance, and UK literature based on this (Shepherd, 1990) reflects this emphasis. Nevertheless, within this broad brush statement may be identified several ideals and operational procedures which could be said to designate case management as relevant to contemporary community nursing in Britain. While the overt "managerial" (including resource management) function, implicit in the title, has been emphasized by some (Cambridge, 1990), the case manager/client interface, with its individualized focus, has served as the vehicle for the promotion of ideals of client advocacy (Thornicroft, 1991), partnership with clients and other agencies (DoH,1989a) and education for empowerment (Richardson and Higgins 1991, Repper and Peacham, 1991). Some commentators see case management in terms of the recipient client groups selected for this form of care, rather than in terms of agencies or values (Papadopoulos, 1992), and these groups span the range of contextual settings, as well as the age ranges and health status which characterize the diversity of current community care. Others, more recently, have attempted to encapsulate the concept within the range of competencies its practice requires (Sherlock-Storey and Milne, 1995). Finally, operational guidelines for the implementation of case management have often conceived of it in terms of five or more core functions or stages (DoH 1989a, Richardson and Higgins 1991, Richardson 1991, Ryan et al 1991), not entirely unlike the nursing process itself, and from where much of the competency-based literature derives:

- Selecting specific individuals for attention (case finding or targeting).

- Seeking to understand their needs (assessment).

- Working out a plan of action to meet these needs (individual programme planning - IPP).

• Putting the plan into effect (service delivery).

• Keeping in touch to see how the plan is working and making changes as appropriate (monitoring/review/evaluation).

Challis (1994a, 1994b, 1994c) has further discussed these different types of definitions.

The varying emphases given by different projects to these functions and values is dependent upon their context and, it could be argued, on the overiding political and managerial imperatives at both national and local levels. These variations can be illustrated in the three-model framework for classifying case management as identified by Beardshaw and Towell (1990).

Advocacy is a prominent feature of the first of these, the "brokerage" model, where the case manager acts as an independent "go-between" for a client and links services to needs. This is an approach which has been occasionally adopted in British case management for people with physical disabilities (Hunter 1988, Pilling 1992) or learning disabilities (Archer and Robertson 1990, Richardson and Higgins 1990, 1991). However, its derivation from North American practices, where case managers are commonly agents independent of service provision, has meant it has less relevance to Britain where case managers tend to be service based or linked (Beardshaw and Towell, 1990).

Resource and budgetary control are central to the second, or social entrepreneurship model (Beardshaw and Towell, 1990), where the case manager holds a devolved budget for the purchase of an individual's care from within and outside statutory agencies. Devolved financial accountability is ideologically conducive to the provision of individualised, needs-led care packages and was a feature of the pioneering Kent Community Care Scheme and its derivatives, described in the work of the PSSRU by Challis and Davies (1986), upon which much Government thinking in the UK was predicated.

Beardshaw and Towell's (1990) third model of case management focuses on the co-ordination dimension of case management and entails the assumption by members of multidisciplinary teams of responsibility for arranging and monitoring care for specific clients in addition to their professional roles with regard to other clients. The case manager is thus an extension of the keyworker role, which is a term derived from the prime workers with elderly people in residential accommodation and, therefore, inclusive of involvement in service provision (Beardshaw and Towell, 1990). The model has been described in practice by Dant et al (1989) in case management for elderly people and, while it clearly has the advantage of being less disruptive in terms of role change for practitioners, it runs counter to the government concept of separating assessment from service provision.

As a post-script to the issue of definitions and models, it may be pertinent to allude to the lack of semantic consensus as to which term best encapsulates the ideals and processes described above. While the term case management, as used in the UK, became enshrined in the public consciousness following its endorsement in the White Paper "Caring for People" (DoH, 1989a), it is also associated with a number of related, but (debatably) distinguishable concepts. These include managed care (Cohen and Cesta 1993, Hale 1995) and mental health arrangements for keyworking, the Care Programme Approach for the receipt of psychiatric services following hospital discharge under DoH circular HC(90)23/LASSL(90)11 (DoH, 1990b) and Section 117 of the 1983 Mental Health Act covering discharge requirements for those compulsorily detained. Recently, the term case management has been largely superceded by the apparently more politically correct phrase care management in subsequent, post-consultation policy guidance. This was on the grounds that "'case' was regarded as demeaning to the individual and misleading in that (it) is the care, and not the person, that is being managed" (DoH/Social Service Inspectorate [SSI], 1991a, p.10). The implication that the two terms are interchangeable, and usage really only a matter of sensitivity and preference, has meant that a number of authorities, such as the King's Fund (Beardshaw, 1991) have followed suit. However, Onyett (1992) has argued that "although the

word 'case' has unfortunate medical overtones and users have stressed that they are not cases to be managed, the phrase does emphasize the individual focus of case management that is perhaps its only wholly unequivocal characteristic"(p.x). Furthermore, Onyett continued, because case management "involves assessing and meeting users' needs rather than managing service provision ('care') *per se*" it is more appropriate than the alternative care management which "obscures the central features of this approach, a focus on the needs and strengths of individual users".

Other commentators (Hunter 1988, Ryan et al 1991) have also argued for a recognition of two levels of describing this modality of care delivery and it is of interest to note that many of the more recent project evaluations (Richardson and Higgins 1991, Knapp et al 1992, Pilling 1992, Ford et al 1993), as well as much North American literature, continues to use the term "case", an indication, perhaps, of where the focus should be angled in the evaluation of community care. Most recently, a differentiation has been made between "mainstream" care management - largely a coordinating role - and what the PSSRU used to call case management (now termed intensive care management), which combined coordination with therapy and support (Welch, 1998). The term "case" will continue to be used in the present context, both because of the intended individual focus and because of the supra-national currency the term already enjoys both in general (Onyett and Malone, 1993) and as applied to nursing. Many of these issues related to definitions, models and terminology will be revisited and discussed further in subsequent sections of this review.

1.2. The context of case management - i) North American perspectives.

1.2.1 Introduction to section

The nature of case management practice undoubtedly owes much to the North American legacy, so its literature merits analysis and is the subject of this section. Both Peck et al (1992) and Challis (1994a) have used examples from North America to raise issues which may

be considered to be of a universal nature, however, the degree of "transferability" of the concept across different contexts must be questioned. Therefore issues of relevance to a different geographical location (the UK) and to a circumscribed profession (nursing) will be explored in the succeeding two sections. Furthermore, the extent to which descriptive evidence can lead to prescriptive conclusions must be limited by the relative failure of this type of literature to focus on any evaluative dimension. Such analysis will, therefore, be supplemented by subsequent examination of designated case management research projects in general, and of those with a nursing element in particular.

Case management literature can broadly be seen to discuss the concept in terms of the interplay between the aims of an initiative and its structural and organizational backdrop, itself often influenced by historical developments. These, in turn, govern the process through which implementation occurs and the outcome measures by which effectiveness is measured. It may be considered useful, therefore, to adopt this approach and these headings (origins, aims, structure and organizational factors, processes, outcomes) to frame the current analysis.

1.2.2 Origins

Although the precise origins of case management are difficult to ascribe, it is generally thought to have evolved from practices in public health, mental health and care of the elderly/long-term client (Bower 1992, Holzemer 1992, Cohen and Cesta 1993, Lyon 1993), with the term first appearing in the social welfare literature of the early 1970s. However, the determinants of case management evolution within these three disciplines, and therefore the dating of related practices, would appear to be variable, especially according to specialist commentators.

In public health, for example, a community service coordination role is thought to have existed from the turn of the century, as a forerunner of case management (Bower 1992, Lyon 1993). Worley (1991a, 1991b), on the other hand, dated the seminal changes in

mental health care from the 1960s, when changes to the finance legislation gave rise to national insurance programmes which facilitated the deinstitutionalization of this client group. Problems arose, according to this author, due to the resulting delegation of care to different agencies, such that the continuity of care previously experienced within a hospital was lost. Ryan et al (1991) have further detailed the course of case management in mental health, dating its popularity from the work of Mary Ann Test and Leonard Stein in 1970. The Federal Government's desire that all people with mental health problems eligible for publicly funded mental health services should receive case management by 1992 led to an explosion in this service provision. Finally, the rapid expansion of human caring professions in the 1960s and 1970s was seen by Intagliata (1982) to have led to fragmented service provision, exacerbated by the complexity of public funding; access for those with complex needs (particularly the elderly) who engage with multiple services was seen to be particularly problematical. Wood (1991) and Lyon (1993) supported the argument that the elderly were particularly disadvantaged within this scenario; Wood contended that the increase in the numbers of elderly meant that, while health and social needs may have been met, this could hardly have been at an ideal level under current practices, while Lyon agreed that this group is unlikely to have been adequately serviced within generic programmes.

But while the incentive to devise new ways of working for these three groups in particular would seem to be strong, evidence suggests that similar changes may be generalized to the care of other specialist groups, resulting in developments along the same principles. In the care of the growing number of AIDS/HIV patients in the 1980s, for example, high caseload numbers, particular difficulties in accessing traditional services and limited choices for service users also demanded new care arrangements (Ryndes 1985, Sonsel 1989). The growth in specialist services at this time, together with the rapidly developing skill and experience of professionals in the field provided incentives towards the development of a case management model (Sonsel, 1989). Meanwhile, changes in morbidity and increased survival rates within the paediatric

specialism resulted in the same trend of growth in the numbers of chronically ill needing community care (Urbano, 1991). Together with finance incentives and the move from hospital to home management, these factors gave rise to further development of the case management approach to the the care of children. Such generalization of trends in respect to different care groups opens up questions of generalizability to other settings and these will be explored in section 1.3). It also raises further questions about the suitability of nurses working with these groups for the case manager role, a practice well established in North America (Cronin and Maklebust 1989, Ethridge and Lamb 1989, Knollmueller 1989, Bower 1992).

1.2.3 Aims

The aims of different case management initiatives can be seen, in effect, as a natural corollary to the underpinning issues related to health and social care in the US enumerated above. Much literature comments on a dual purpose here, in the form of what Lyon (1993) described as both client-centred and system-centred functions. Client-centred functions are centred around the promotion of quality care (Brown 1989, Petryshen and Petryshen 1992, Cohen and Cesta 1993) and this general approach has its outworkings in, for example, advocacy (Sonsel 1989, Bower 1992), continuity and coordination of care (Intagliata 1982, Sonsel 1989, Lyon 1993), improving access (Intagliata 1982, Lyon 1993) and generally assisting the client through what can be a complex health care delivery system (Lyon, 1993). Interestingly, these process-orientated aims seem to far outweigh intended client outcomes in the literature, though Lyon (1993) did include improved patient functional capacity at the end of a list of case management objectives.

System-centred functions focus with one voice on cost containment (Brown 1989, Sonsel 1989, Wood 1991, Petryshen and Petryshen 1992, Cohen and Cesta 1993). However, the interpretation of this notion varies. Intagliata (1982) questioned the common assumption that cost-control necessarily equates with the other much used (and often preferred) term "efficiency" in this context, when, in practice,

the latter often results in the identification of more client need and consequent delivery of more services. Lyon's (1993) more overt (and perhaps more honest) claim for rationing and priority-setting when resources are limited as system-centred functions would seem to support this view. Either way, there appears to be a transparency of intent displayed in the US literature which may seem foreign to a British observer of policy making, though questions of transferability of principle must, again, be raised. As Bower (1992) has argued, goals related to both service outcome and cost-effectiveness are necessary considerations in most care services and "to accomplish this mandate the relationship between the costs of care, the desired outcomes of care and the processes involved in providing care must be re-examined" (p1). Such processes and outcomes will, therefore, be addressed in this review. But, first it is important to make explicit the mediating structural/organizational factors which obtain in the North American scene.

1.2.4 Structural/organizational factors

Intagliata (1982) has not been alone in emphasizing the need to have the appropriate structures in place before implementing case management, but has, perhaps, given the subject greater prominence than other writers. In particular, this author stressed, as pre-requisites, the need for core agencies capable of providing new services to meet emerging requirements, and the need for formal contracting mechanisms. Indeed, he went so far as to claim that there is "indication that case managers' actual activities are shaped ultimately by the constraints of the environment within which they work, not by the formal job description" (Intagliata, 1982, p.670). Petryshen and Petryshen (1992) and Cohen and Cesta (1993) likewise emphasized the need for a framework of total organizational commitment to restructuring care in order for case management to be achievable.

It could be argued, of course, that institutional restructuring, or "re-engineering" (Humphreys, 1996) is not a new concept in the United States and that it has led to, rather than been the result of, the impetus towards case management. One such structural framework

with which case management is often linked by a number of authors (Knollmueller 1989, Bower 1992, Cohen and Cesta 1993, Hale 1995, Conger 1999) is managed care. Although Cohen and Cesta (1993) noted that the terms case management and managed care are often used interchangeably in North American literature, they have identified a number of similarities and differences which would seem to render them at once synergistic but capable of separate existence - and this is a point of potential relevance to the UK where managed care is still a newly emerging ideal.

Although the aims of both are similar (and as discussed above), Cohen and Cesta (1993) argued that while case management is conceptualized as a process model, managed care is viewed as a system or generalized structure within which care is managed. Moreover, managed care does not target a client group - unlike case management - and, while consistency of care is promoted, this does not rely on a consistent individual (or set of individuals) as would be embodied in a case manager or case management team. Rather, such consistency is attained through "critical paths" - standardized patterns of care events constructed in response to problem lists and expected outcomes, the courses of which are contained within "care maps" (Petryshen and Petryshen, 1992).

Such a generalized approach to care planning might seem to be at odds with some interpretations of case management, where it is seen primarily as a way of promoting an individually needs-led approach to service delivery, and this casts doubt on the compatibility claimed between the two concepts. Indeed, this is a further difference between case management and managed care identified by Bower (1992) and Hale (1995). Hale (1995) has described case management as the individualization of a standard managed care programme, which immediately suggests limitations in the degree to which "individualization" can, in fact, take place. Bower (1992), on the other hand, saw managed care as a strategy adopted by purchasers to influence aggregate utilization levels of services, whereas case management focuses on the individual client level of care. Both of these points raise issues of potential relevance in the transference of case management to a British community care scene. The first is,

possibly, less problematical, given that managed care is less likely to operate within community settings. The second, however, suggests the possible need for an alternative mechanism (in the absence of managed care) to cope with the need to address population, as well as individual, need in planning care.

1.2.5 Process features

Despite the assertion that case management can also be viewed as a service, programme, role, system or technology (Wood 1991, Bower 1992), it is, perhaps, helpful in this context to consider it primarily as a process, as Cohen and Cesta (1993) have suggested (above), since this invites comparison with the nursing process (Bower 1992, Conger 1999). It also raises questions and issues concerning implementation and operationalization, which may help ground the concept in actual practice (and, possibly, help to address the issue of individual versus aggregate needs raised above). This "unpacking" of case management practices is not to deny the usefulness of Beardshaw and Towell's (1990) tripartite conceptualization (section 1.1.3), but perhaps helps to clarify how, in the real world, where practice does not always readily dovetail with theory, elements from different models may become features of new and appropriate ways of working. It may, in addition, help clarify the huge variety of terms used to classify and describe case management, not readily understood out of context. These features will also be closely linked to wider issues such as who is acting as case manager, the precise functions of case management and the nature of the target group.

One of the ongoing debates in the North American literature (Worley, 1991a) concerns the degree to which case management should be a pure brokerage function, rather than include elements of service provision or therapy. The broker model in North America appears to operate in the main where case managers (including nurses in this role) are either independent or employed by companies (Kollmueller, 1989) and is said to promote autonomous decision-making by the practitioner (although Cohen and Cesta [1993] seem to suggest that what they termed private case management, outside publicly funded programmes, provide more direct services).

This brokerage model can be equated with Worley's (1991a) "administrative" model and Cohen and Cesta's (1993) "generalist", and is opposed to the "primary therapist" (Cohen and Cesta, 1993) or "clinical" (Worley, 1991a) model, which is characterized by a therapeutic client - case manager relationship. Here the case manager therapist necessarily comes from a professional background relevant to the appropriate therapy, and may represent one of a variety of disciplines. For example, in mental health this may mean psychologists, psychiatrists, social workers or psychiatric nurses working as case managers (Cohen and Cesta, 1993).

Extending this issue, within the broker vs. therapist debate, of who should be the case manager brings in the related issue of the nature of the targeted client group. A "primary therapist" model would imply possession by a case manager of skills relevant to the discipline and client group within which the individual worked (Cohen and Cesta, 1993). More generally, case manager designation may at least be guided by the relative health/social needs of a client group, with Cohen and Cesta (1993) identifying three categories based on these dimensions: (1) social case management, where health and social needs are markedly present (as with the elderly) and may call for the multidisciplinary team approach; (2) primary care case management, which is based on a medical model, where treatment of health problems predominates and the physician generally works as case manager; (3) medical/social case management, which is the model of choice for the long term care of a client population at risk of hospitalization and where the case manager may be one of a number of professionals - physician, social worker, nurse or even family.

Another process debate concerns whether case management should be undertaken by either one individual or a team. The assumption that one individual carrying out all core functions involved in case management would be most conducive to achieving the aims of continuity and coordination has been challenged by Intagliata (1982), Worley (1991a) and Cohen and Cesta (1993), who claimed that for some areas of practice, such as mental health, a team may be more appropriate in order to harness the diverse specialist skills needed

for this client group (which may include housing, rehabilitation, recreation, nursing etc.)

A "team" in this context may mean either all these professionals acting as case managers, or one designated case manager calling on the skills of other professionals, and Intagliata (1982) suggested that either of these models has the advantages of maximizing expertise, avoiding isolation and contributing to continuity and coordination across disciplines. The team concept is, perhaps, similar to Beardshaw and Towell's (1990) multidisciplinary team model, and certainly shares elements with the coalition model described by Ryndes (1989) as applied to people with AIDS. Its alternative, the individual case manager model, has also been termed the "generalist" model by Worley (1991a), in the sense that the individual carries out all the functions of case management, rather than calling on specialist workers. This is, perhaps, unfortunate, since the same term was used by Cohen and Cesta (1993) (see above) to describe the broker (as opposed to therapist) model, in which context "generalist" is taken to mean the case manager is not affiliated to any particular profession. This is but one example of the way confusing case management terminology can make it difficult for those wishing to apply concepts to practice.

Yet another example of the polar interpretations of case management which exist is seen in the divide between the "intensive" or "assertive" forms and the more "minimalist" practices. Worley (1991b) described the assertive model as of recent origin and highly labour intensive, and would probably recognize its characteristics in Intagliata's (1982) "comprehensive" type, which adds to the core functions those of outreach, direct service provision and advocacy. However, Intagliata (1982) preferred to see these extreme dimensions of case management described in the literature not as contradictory, but rather as a range of options along a continuum, which vary according to the amount of control over provider agencies exercised and according to the needs of the specific client group being targeted. In other words, there is a need, he claimed, for flexibility of practice, which may mean that "substantial differences typically exist between officially mandated patterns of

case managment activity and actual patterns of service" (Intagliata, 1982, p.659).

The particular options selected along the various continua of characteristics which constitute case management will inevitably affect many of the details of practice. For example, figures quoted for optimum caseload numbers vary widely in the literature. Kemper et al (1987) quoted 45-125, dependent on whether an individual or team model operates. Intagliata (1982) quoted the ideal of 15-30 for individual case management (with 40-55 if intervention is limited to crises only), while Worley (1991a) contended that intensive case mangement practice can only work with caseloads up to 10. Another example of variation in detail concerns payment arrangements, which may be settled by contracting agencies or grants (Ryndes, 1989) or through waivers in Medicare/Medicaid (Kemper et al, 1987) among other options.

That said, certain themes appear consistent throughout the literature, irrespective of model under analysis. The need for adequate education and training for the case management role and subsequent supervision has long been recognized (Intagliata 1982, Ryndes 1989, Conger 1999) and ethical issues abound, particularly related to advocacy and the allocation of resources (Worley 1991b, Kane et al 1994). Worley (1991b) pointed out the potential conflict of interest where advocates are employed by the same agency that pays for, and often provides, the services, while Kane et al (1994), in a survey of 251 case managers, using both open-ended and structured questions, highlighted six main areas where ethical issues may create tension. These included divergence in client/family or client/case manager views, safety issues, confidentiality, interagency problems, bureaucracy and underfunding. In order to cope with what they described as an "ethical minefield", these authors recommended the publication of guidelines to help case managers when faced with the inevitable compromises which must be made in everyday practice.

Yet, despite the extreme variability of case management practices apparent in the US literature, there is also a note of unifying structure evident. Such literature emphasizes the importance of

linking the different levels of service provision with which case management must articulate in order to result in effective practices. Intagliata (1982) and Thomas and Towell (1990) have enumerated these various levels and their responsibilities: state level authorities were identified as having an enabling role and allocating responsibilities to particular agencies; local authorities need to ensure that the structural pre-requisites for case management are in place, fix responsibilities more specifically and, above all, possess and disseminate the "vision" for good practice; and individual case managers provide the link between the client and the system.

This individual relationship appears to be at the heart of case management. Indeed, Intagliata (1982) has suggested that "perhaps the most influential aspect of the case management process is the quality of the personal commitment that case managers develop towards their clients" (Intagliata, 1982, p.660). But in order to support this emphasis, there is clearly a need for long-term, multi-level strategies, particularly where it is intended that small scale demonstration projects become absorbed into government policy (Thomas and Towell, 1990). This message is perhaps of relevance wherever new service delivery systems are being introduced. However, in order to establish how these levels may be interlinked to best effect, Intagliata (1982) has suggested that research is needed on how these contextual variables, including individual characteristics of case managers and local service availability, influence case management processes.

1.2.6 Outcome measures

In general, the US literature suggests that case management has mixed results, and evidence supporting its purported advantages is weak and variable in quality (Worley 1991a, Holzemer 1992, Hudson 1992, Hale 1995). Worley (1991a) has commented that, in any case, research on outcomes is at an early stage, while Kemper et al (1987) advised caution in interpreting results, since very different measures are used in individual studies, making generalization unwise.

However, limited conclusions may be drawn regarding the value of North American case management by analysing claims as to how far it is said to have achieved the aims laid out above. The extent to which these outcomes can then be said to be predictive of case management in general must proceed to take into account any equivalence with the process features, as described.

Outcomes are particularly variable regarding the central issue of cost. While Worley (1991a), Holzemer (1992) and Conger (1999) claimed cost-effectiveness for at least some types of case management practices, Knollmueller (1989) has suggested that benefits are not yet in line with costs. Kemper et al (1987), in a review of 16 community care demonstration projects which included case management for the impaired elderly in the 1970s and 1980s, found that aggregate costs, if anything, tended to rise. The authors questioned whether case management should be justified primarily by cost-savings or rather by the distribution and quality of benefits within the amount which society is willing to pay.

A number of commentators have, in fact, looked at potential service benefits and here the findings are, perhaps, more positive. Cohen and Cesta (1993) claimed improvement along a number of parameters, including access, assessment procedures, care planning, coordination between health and social care, quality of life measures and reduction in hospitalization time. Some of these measures, especially quality of life and functioning, have been echoed by others (Kemper et al 1987, Worley 1991a Holzemer, 1992). However, Kemper et al (1987) found no difference in nursing home use and little difference in hospital use between case managed and non case managed groups, while Holzemer (1992) commented on the paucity of evidence on patient satisfaction and preferences and community initiated case management.

1.2.7 Summary

This section addresses the first aim of the review. It seems, as Knollmueller (1989) has warned, it is not necessarily advantageous to be quick to jump to something because of the popularity of the

term. This is an issue which will be addressed again in the next section, in applying case management to the UK scene. Regarding North America, the main points from the selected literature reviewed may be summarized as follows:

• Factors predisposing to the development of case management comprise a combination of those particular to an individual specialist area and those common to the service delivery system in which it operates.

• Aims of case management may be both client-centred (coordination of care, improved access, advocacy etc) and system-centred (cost-containment/cost-effectiveness).

• Structural factors influence, and reflect, case management aims and practices. These include the adequacy of service provision and arrangements for "managing" care and addressing individual, as well as population, needs.

• Good case management depends on a coherent framework to link all levels of operation from policy making, through local systems, to the individual case manager-client relationship.

• Variations in case management practice are evident, eg:
  - broker vs. therapist model
  - individual vs. team case management
  - intensive vs. minimalist practices.

and these may be appropriately different according to setting, client group(s) and case manager designation. However, ethical issues appear to be inherent in any form of practice.

• Documented outcome measures of case management are variable. Evidence suggests that, though it may be beneficial to clients along a number of parameters, service costs may rise, rather than fall.

1.3. The context of case management - ii) The UK policy setting

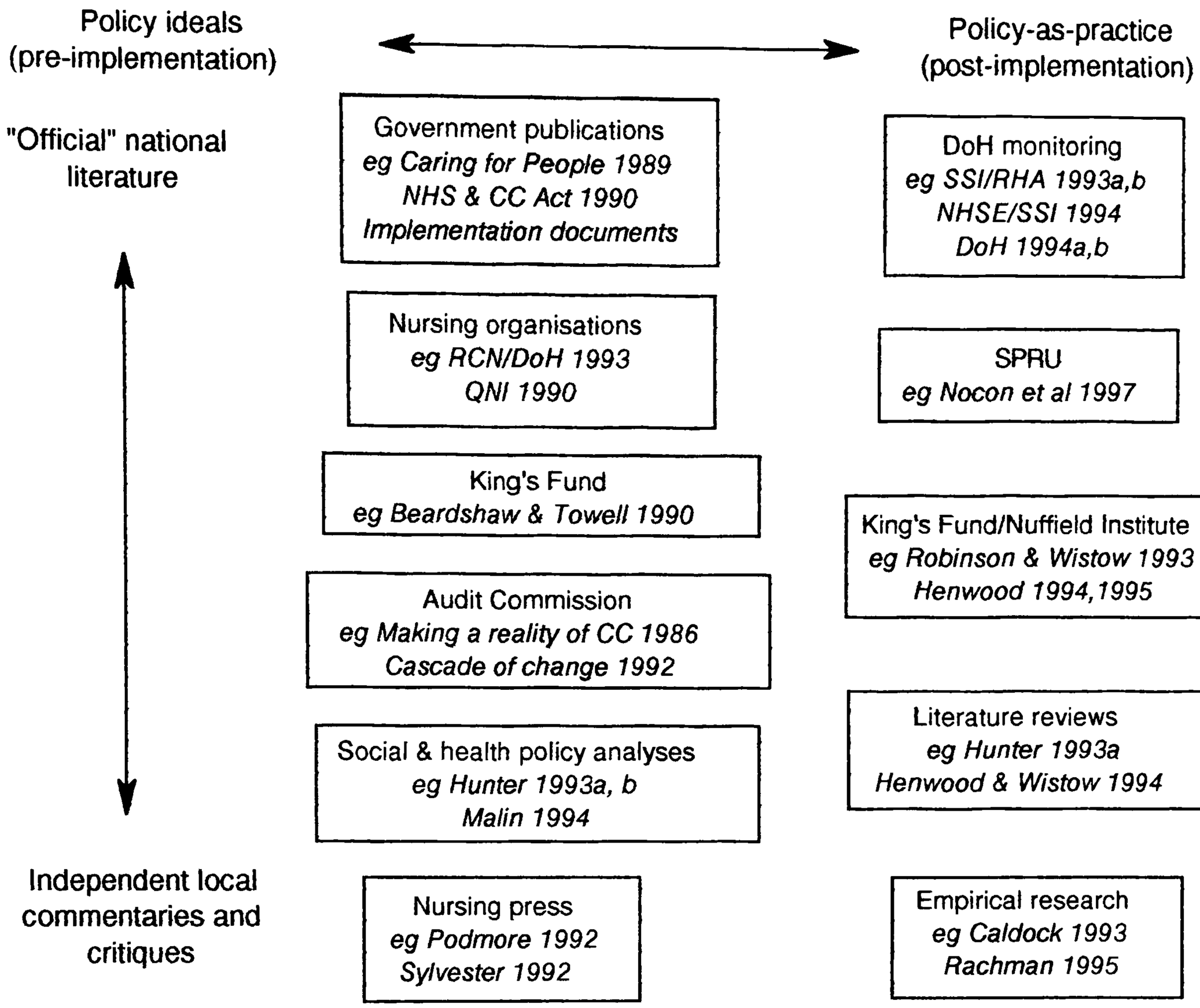
1.3.1 Introduction to section

In the United Kingdom, case management has become firmly embedded within the policy of community care. Although, as stated above, policy as a determinant of both care practices and their ideals is an explicit assumption of this review, there exists a parallel thesis in much related literature (Lipsky 1980, Malin 1994, Lewis and Glennerster 1996) that other factors come into play which give rise to what Trnobranski (1995) has called "implementation deficit" - the tendency for policy intentions to be transformed rather than be flawlessly achieved. Although this section will, therefore, focus largely on policy ideals, it will also touch on their outworkings in processes and actual practices, in analyzing how they serve as a context for community nursing.

There are a number of dimensions to this approach as a vehicle for reviewing the literature. Firstly, the ideals-practice dichotomy may be approximated with the timing of any writing around actual policy implementation. Generally speaking, literature appearing prior to implementation of the NHS and Community Care Act (1st April 1993) has tended, not surprisingly, to be "ideas" based and forward looking, while any appearing subsequent to that date has tended to be more grounded in actual practice and retrospective evaluation. Secondly, and in addition, the literature can be categorized by type, according to its degree of proximity to the "official" line in its source. Within this continuum, government legislation represents the extreme "official" end, while independent critiques, analyses and research represent the opposite extreme. These timing and type dimensions are represented in the schema in fig. 1.2. An awareness of both is obviously of importance in offering a critique of such literature.

Thirdly, there are also a number of recurrent issues in the community care literature (table 1.1) which will impact upon community nursing, serving in the main as extrinsically imposed, structural determinants. The more intrinsic, ideological factors in the professional construction of the discipline will be addressed in the next section. Lastly, in

Fig 1.2 Timing and type of case management literature reviewed



adhering to the cumulative nature of the review, comparisons will be made where appropriate, with the reported evidence gleaned from the North American experience already reviewed.

Table 1.1 Issues recurring in the community care literature

- Resources and funding
- User involvement
- Collaboration between social and health care agencies
- Levels of responsibility (national/local/individual)
- Levels of focus (community/individual)
- Practice specialisms
- Models of case management in use

1.3.2. Background to community care in the UK

There is consensus in the literature that the concept of community care is not new. Despite what some see as a failure by successive governments to adequately define the nature of either "community" or "care" (Caldock 1994, Nolan 1996), some form of planning system for health and personal social services under that, or a similar, title has long been a feature of UK policy makers.

However, the dating of its origins varies. Orme and Glastonbury (1993) have traced a form of community care back 100 years to the domiciliary parish or outdoor relief system, while Lewis and Glennerster (1996) and Hunter (1993a) dated its inception to the late 1940s and 50s, with the start of the shift of care for certain client groups from inappropriate institutions to suitable residential accommodation. While a number of commentators - and, indeed, the Government itself - have, from the perspective of the 1990s, detected some commitment to community care over the last 30 years (Nolan 1996, Clarke 1989, Wistow and Hardy 1994, Lewis and Glennerster 1996), it is the decade of the 1980s, with its accompanying financial crisis, that has been seen by most as crucial to the contemporary manifestation of the term (Papadopuolos 1992, Wilson, 1993, Trnobranski 1995, Wistow and Hardy 1994, Lewis and Glennerster 1996).

The roots of the UK financial crisis of the 1980s are, generally speaking, acknowledged to lie in the discretionary supplementary benefit payment system, which assisted elderly residents in private residential or nursing homes (Beardshaw and Towell 1990, Knapp et al 1992, Wilson 1993, Trnobranski 1995, Lewis and Glennerster 1996). Though little used initially, this system of exploiting social security payments became, in the 1980s, attractive to cash-strapped health authorities and social services departments as a means of securing residential funding for their elderly clientele. Lewis and Glennerster (1996) have argued in their analysis of the issue that these so-called perverse incentives (because of the consequent encouragement of institutional, rather than domiciliary, care) were maintained largely because of the vested interests, not only of private

residential or nursing home owners, but also of the Conservative Prime Minister of the time, Margaret Thatcher, with her desire to retain the support of small business owners such as these. By the time the system was subject to its first major critique in a report by the Audit Commission (1986), this was the fastest rising element in public spending, the sum spent to date amounting to some £500 million. Thus, the authors argued, the community care reforms emerged primarily as a means to contain spiralling costs, rather than to improve services, and subsequent ideological motives were put forward mainly to appeal to other involved interests (particularly users, carers and social service departments).

Thus certain features of the origins of community care - a move to deinstitutionalization, a focus on particular client groups and financial concerns - immediately resonate with the picture already depicted in North America. However, the particular manifestation and inter-relationship of these features in the UK illustrates the difficulty in establishing a definitive basis for policy ideals, even before their translation into practice. Knapp et al (1992), in describing the 1983 Care in the Community circular (Department of Health and Social Security [DHSS] 1983) which announced funding for 28 care in the community pilot projects, have described community care at that time as being only a "sketchily drawn option...like the early stages of a jigsaw, the edges were in place and a few key pieces were correctly located, but the picture remained for local agencies to complete" (p.8). The actual combination of political imperatives and declared ideologies in the reforms which subsequently took place appears to have emerged from a dual impetus - on the one hand policy guidance from official reports and, on the other, the general contemporary conceptual framework for developing the post-war welfare state. Both of these issues merit some analysis.

At a time characterized by what Orme and Glastonbury (1993) have described as being "littered with major social service reviews", two reports are repeatedly mentioned in the literature for their impact upon subsequent policy statements (Smith 1993, Hunter 1993a, Wistow and Hardy 1994, Lewis and Glennerster 1996). The report, already referred to, of the Audit Commission (1986), an independent agency

with a remit for overseeing local authority spending, identified the fragmented nature of community care (as in North America) and criticized the funding arrangement which underpinned this as a major cause. The Griffiths Report, commissioned by the Government itself to review and advise on community care, followed on two years later (Griffiths, 1988) and contained what Smith (1993) has seen as a more explicit acknowledgement of the financial problems being experienced by social and voluntary services. In the radical proposals put forward to deal with the problem it was suggested that public finance should support vulnerable groups of people requiring residential or nursing home care through the transfer of social security payments to Local Authorities, which would be charged with assessing and meeting the needs of these people following a formal assessment. A further major feature (though seen by Lewis and Glennerster (1996) as merely a secondary proposal to win over Mrs Thatcher) was the notion of the so-called "mixed economy of care", by which Local Authorities would contract out to various independent agencies the actual delivery of the services needed, retaining a largely commissioning role for themselves. It was within these economic and structural changes that Griffiths (1988) proposed the introduction of case management, which would effectively link the - albeit possibly incidental - ideals of a needs-led, individualized seamless care delivery system with the need to reform and retrench community care spending.

But beyond these immediate proposals for reform lay what some analysts have seen as a broader ideological backdrop to the post-war welfare state in the UK and beyond. This "New Public Management" (Hunter 1993a, Trnobranski 1995) was characterized by professional management efficiency, cost reduction, the development of quasi-markets, a purchaser-provider separation and the development of the private sector. It is not difficult to recognize these features in the 1980s proposals for community care, which Trnobranski (1995) described as merely part of this larger political agenda and not, therefore, necessarily radical or out of place. Indeed, Hockey (1995), in a retrospective analysis of the first few years of community care has argued much the same point in terms of its effects on community nursing. For example, Hockey argued, marketing of nursing was

actually established as long ago as 1948, when, in the wake of the first 1946 National Health Service Act, district nurses often contracted out to voluntary associations.

However, notwithstanding an impressive outpouring of reports and recommendations, as well as a political climate sympathetic to the new management ethos, the question of the link between policy ideals and practice remains. While, on the face of it, the care in the community programme launched by the DHSS in 1983, could perhaps be said by the less critical commentaries to be about "improving the quality of life, rights and status of those who need it within their chosen environment" (Papadopoulos, 1992, p.ix), concern was also voiced that its underpinning policy was bolstered more by optimism, rhetoric and "tangentially relevant research" than a sound knowledge and evidence of the actual workings of community care (Knapp et al, 1992, p.5).

1.3.3 Caring for People

Given this background, apparently conducive to the development of a "market culture" and, more particularly, the suggestion that this trend could be harnessed to a need to reduce public spending, it is, perhaps, not surprising that the two major White Papers which presaged government legislation on health and social care in England (DoH 1989a, 1989b) were, as the official expression of government ideals, in keeping with this way of thinking. It is interesting, if maybe unfortunate, that it was in "Working for Patients" (DoH 1989b), which dealt largely with the acute sector, that the greater emphasis was laid on health (as opposed to social services) changes. Nevertheless, with its proposals to delegate responsibilities to local levels by, among other things, the creation of so-called self-governing hospitals, reformed management and new funding arrangements in support of the purchasing ethos, the principles which would guide the development of health care in the community may be detected.

The community-focused paper, in contrast, very much emphasized the role of social services. Although "Caring for People" (DoH, 1989a) defined the Government's view of community care in terms of an

ideology (service provision tailored to meet the needs of those client groups in greatest need so as to promote independence), the "key changes", which formed the substance of the paper, had a structural, rather than ideological, emphasis in the stress on the responsibilities of local authorities. These responsibilities included:

- the assessment, designing and delivery of care packages
- the production of community care plans
- maximizing use of the independent sector in the purchase of care provision
- responsibility for the financial support of individuals in private and voluntary residential accommodation, under the new funding arrangements, whereby monies would be transferred from social security to social services departments
- the establishment of inspection units to monitor these homes "at arms length"

Reaction to the community care proposals was not uniformly enthusiastic. Despite the obvious intention of the then Secretary of State for Health to portray the Government as being receptive to the country in emphasizing the 280 responses to the Griffiths Report which he had taken note of (Clarke, 1989), "Caring for People" (hereafter referred to as the White Paper) itself was said by one team of policy analysts to have been likened by Griffiths (1988) to a "three wheeled version" of his "vehicle" in view of the number of proposals dropped at this stage (Wistow and Hardy, 1994, p.49). Orme and Glastonbury (1993) thought the White Paper "scarcely novel", suggesting it merely repeated policy of previous years, while others detected a number of tensions, conflicts and contradictions within its various emphases (Beardshaw and Towell 1990, Hunter 1993a, Caldock 1994, National Association of Health Authorities and Trusts [NAHAT], undated(a)).

Nevertheless the government's proposals became enshrined in legislation in the form of the NHS and Community Care Act, 1990, which Malin (1994) described as essentially a replication of the framework of the White Paper, if "short on its commitments" (p.8). It was, however, "marooned for two years" (p.8), and staged

implementation did not reach completion until 1993. This gave supporters and critics alike an extended timescale during which to hypothesize over the impending legislation, and the literature of the period was characterized by a plethora of policy summaries produced by interested parties (National Council for Voluntary Organizations undated, John Grooms 1989, Age Concern 1990, NAHAT undated[a]). Most of these publications were produced with the aim of highlighting relevant issues of the particular group represented (in this case, voluntary workers, the disabled, the elderly and health services respectively), but some were pointedly questioning of whether the Government could deliver its promised agenda. For some groups the questioning and uncertainty was reinforced by the appearance of concurrent Government legislation, which, while often appearing to dovetail with the community care ideals, frequently failed to specify how the dual systems should be operationalized, for example the Care Programme Approach (CPA) in mental health (DoH, 1990b), the Disabled Persons Act, 1986, the Carers (Recognition and Services) Act 1995 and proposals for long term health care.

1.3.4. Implications for community nursing

But if uncertainty in general characterized the response to the reforms, the role of community nursing, in particular, within the new structure was less than clear. The White Paper itself saw community nurses as having a "very significant role" (para. 2.6) to play in community care which seemed to major on both care delivery (with that care being in the social and psychological, as well as health, domains) and also a coordinating, networking role, with possible keyworking activities. The Government was also concerned to make what it termed the best use of nursing skills by delegating work which could be done by others.

Reactions from the nursing profession were mixed, but few accepted the status quo envisaged by the White Paper *vis a vis* joint working. Lightfoot (1995) feared that, given the Government's stance on the health/social divide and skill use, nursing role descriptions were likely to be more tightly drawn and services targeted for withdrawal where

defined as "social". But many looked beyond the health/social issue in questioning the impact of the reforms on community nursing and predicted that all areas of practice would be affected, from assessment and documentation of care, to setting eligibility criteria, training and involvement in community care plans (Smith, 1993). George (1993a), while admitting that the consequences of the Act were not easy to predict, felt that they were likely to give rise to an increased workload and higher dependency patients at the least. His fears were not without credibility, given that Johnston (1993), the nurse member of the Government's Task Force (and, therefore, likely to be in touch with the profession's feelings) also perceived concerns surrounding workload, cost and resource pressures, as well as interprofessional mistrust.

A number of commentators portrayed nurses as instinctively negative in their reactions to the forthcoming changes, viewing them as "threatening" (Hockey, 1995), a "great upheaval" (Sylvester, 1992) and "worryingly close", with many being unaware of what the reforms would mean (Podmore, 1992). Antrobus (1997) painted a pessimistic picture of nurses being exposed to the whims of politicians and health policy makers, and unable to influence the broader health picture.

At the same time, however, there were signs of optimism, often appearing in tandem with the more negative views and urging community nurses to transcend these difficulties. Podmore (1992) and Hockey (1995), for example, saw nurses as key players in community care who should be grasping the opportunities presented to enhance their role. Like Sylvester (1992), who presented some examples of good practice in joint working, those authors believed there was a need for nurses to regain their confidence and skills at this time.

The tension between these two viewpoints regarding the position of community nurses - on the one hand as helpless pawns in the policy makers' game and, on the other, as accountable professionals able to influence their own destiny - is interesting, and was reflected, to a certain extent, in the different ways the balance between central and local control was seen to operate in the reforms in general. It was said

that, whereas the Griffiths Report (Griffiths, 1988) had a strong localist element, while retaining central direction, Caring for People (DoH, 1989a) subsequently advocated a less "hands on" role for the Government (Wistow and Hardy, 1994). Indeed, the White Paper, while indicating a strategic monitoring role for Health Authorities at regional and district level (paras 4.3, 4.25), also made it clear that the difficult issue of defining what constituted health and social responsibilities should be decided at local level (para 6.6).

This approach was obviously of concern to some analysts who detected a vagueness in the meaning and tone of the subsequent legislation, which would be left to local agencies to interpret (Malin, 1994). Thus it was felt that collaborative endeavours, and other aspects of policy implementation, were often reduced to the responses and judgements of individual professionals (Caldock 1994, Lightfoot 1995, Roberts and Priest 1997), so giving rise to Trnobranski's "implementation deficit". Trnobranski (1995) explained the mechanism in terms of a theoretical framework which held that policy implementation encompasses acts by public and private individuals and groups, directed at achieving the objectives set forth in policy decisions. However, these individuals/groups, particularly at the lower end of any organizational hierarchy, do not necessarily carry out superiors' instructions faithfully, but rather exert their own power and make their own decisions. The theory is not unlike Lipsky's (1980) theory of "street level bureaucrats", where, because of the amount of autonomy and discretion allowed to professionals operating at "street level", their practice actually *becomes* the public policy itself. This theory will be further discussed in relation to the nursing profession in the next section.

1.3.5 Assessment and case management

Many of the issues surrounding the implementation of community care at a broad level became crystallized around the introduction of assessment and case management at the micro level. The literature on the subject displayed widely differing interpretations of policy statements, a confusion which Lewis and Glennerster (1996) attributed to the nature of official guidance to Local and Health

Authorities at the time - plentiful but "delphic" in nature (p.13) and "couched in generalities"(p.10).

It is worth noting that as far back as the Griffiths Report (Griffiths, 1988) case management was conceived of in terms of a managerial/overseeing function, such that "where care is already effectively being managed, this proposal will amount to little more than making roles explicit" (para 6.6). The interpretation was continued through the White Paper (DoH, 1989a), where case managers were to "take responsibility for ensuring individual needs are regularly reviewed, resources are managed effectively..."(para 3.3.2) and into the official Practitioners' Guide (DoH/SSI 1991a) where "assessment and care management [as it had become by then] constitute the core business of arranging care..." (p.5).

This managerial emphasis is, perhaps, not unexpected, given the economic backdrop against which case management was introduced. However, Orme and Glastonbury (1993), while giving the concept a cautious welcome from a social service perspective, suggested that, despite the North American influences which placed a greater emphasis on project management than on professional practice, it would be too simplistic to see case management primarily in terms of a means of resource control. Rather, the authors saw it in a dual capacity, as both a method of (social work) practice, relating to clients, and also a style of service management, to do with service planning and delivery. Like Beardshaw and Towell (1990) in their survey of case management for the King's Fund, Orme and Glastonbury (1993) pointed out the danger in comparing the UK experience too closely with North America, and put forward a number of possible models, or "diversity of approaches" in Peck et al's terms (Peck et al, 1992 p.9), which may be developed in the UK. This was also the line taken by Challis, perhaps the most prolific writer on case management in the UK in the late 1980s and early 1990s, and certainly one of the most influential, for his work with the PSSRU on projects in Kent and Gateshead (both visited by Griffiths and mentioned in the White Paper (DoH, 1989), giving some indication of the government's own approach to case management). While seeing case management as a means of managing some of the policy and

practice dilemmas of the time, and despite what he detected as expressions of preferred forms of case management in the DoH guidance, Challis (1994a) saw room for considerable variation in interpretation and methods of case management in the UK, due to its relative newness and lack of evidence to date on outcomes. These variations extended across case manager role, case manager designation, case management users and management issues such as prioritization and the allocation of responsibility to appropriate levels within the manager-practitioner structure. A reading of the "official" literature (DoH 1989a, 1990a, DoH/SSI 1991a &b), with its tendency to ambivalence, at least partially explains such differences, which were also picked up by a number of commentators (Papadopoulos 1992, Peck et al 1992, Orme and Glastonbury 1993, Challis 1994a, 1994b, 1994c).

These issues of theoretical debate over assessment and case management in general, and of case manager designation and levels of responsibility in particular, became a testing ground for actual practices in much empirical research. Generally, findings were not encouraging. Even arrangements for assessment, the mandatory element of the new care arrangements, took longer than anticipated to mature. "Official" sources noted early on that case managers were heavily loaded with new referrals and had reduced time for therapy and counselling (SSI/RHA 1993b). By the second half of 1994, although assessment arrangements were "maturing", there still existed - even evidenced in self-assessment - a service-focused response (NHSE/SSI 1994). Caldock's (1993) survey of practitioners in 1991 was something of a prognosis of this evidence, which she ascribed to the poor quality of guidance on the subject:

> "Despite the plethora of recent documents on the subject, it is very clear that many central issues and questions about who should assess and how they should assess remain unsolved and unclear in the minds of practitioners" (Caldock, 1993, p.144)

Part of the problem of assessment lay in the (previously noted) difficulty of reconciling a system essentially focused on the individual (the "case"), with a need also to serve a local population. Lewis and

Glennerster (1996) commented on the lack of guidance on how to make aggregate needs manageable by linking the "macro" to the "micro" and the "top-down" with the "bottom-up" approach. North's (1997) study of health commissioning bore this point out; this noted the contrast between "the Health Commission (which) was obliged to assess needs of the local population", and "the care management model adopted by the SSD Services (which) focused on individual needs" (p.381). It is interesting that, once again, case management here is automatically assumed to be a social services responsibility. It is also interesting that one of the main barriers to its effectiveness appears to lie in poor interagency integration.

But if part of the problem with assessment lay in the different levels of need due to different agency structures, it also lay in the differences between the levels of professionals within an agency. The observations made above about poor interagency work at the field level compared to the management level (Caldock 1993, NHSE/SSI 1994, Lewis and Glennerster 1996) was also true about knowledge and perceptions about assessment and case management. Caldock (1993) and Henwood (1994) both found contrasts here, though the local Interchange project described by Titterton (1994) did reveal a more positive picture, with a recommendation that skills and commitments at all levels were a pre-requisite to success.

Interpretation of the case management role within community care demonstrated as much variation in practice within these studies as the theoretical debate had forecast. For example, the SSI/RHA (1993b) study found that initiatives were divided between those seeing case management as a process, involving a range of staff, and those seeing it as a function, performed by individual case managers. Meanwhile the NHSE/SSI (1994) monitoring found that in some instances eligibility criteria were used, while in others case management was made available to all. The extent of separation between assessment and case management also varied considerably. Whether these points should be seen as inconsistency, or an ability to adapt to local needs was not made clear.

Case manager designation, not surprisingly, tended to favour a social service orientation, though community nurses were sometimes a minority in the role (SSI/RHA 1993b, NHSE/SSI 1994). The "dear colleague" letter accompanying the SSI/RHA (1993b) monitoring suggested that, in the light of the initial experiences of community care, the government still maintained its stance on the appropriateness of health professionals, including community nurses, in the case manager role (DoH, 1993). Also still under debate following initial findings was the desirability of users and carers as case managers (NHSE/SSI, 1994) and whether case management demanded distinctive skills of its own, rather than being seen within a social work (or other professional) perspective (Henwood 1995, Rachman 1995).

Management issues highlighted in the studies revealed problems with case reviews (SSI/RHA 1993b, NHSE/SSI 1994), the effect of change in terms of insecurity and anxiety (Caldock, 1993), and the need for appropriate training for case managers (DoH, 1993). General conclusions about the success of case managment were mixed. Robinson and Wistow (1993) felt that, by the time of their study, case managers were beginning to make a difference by buying services for individuals. Others were less enthusiastic. For Richardson and Pearson's (1995) 37 study participants "the concept and reality of care management, so central to the community care reforms, was non-existent"(p.286), while Marshall (1996) wrote scathingly of how the concept had affected mental health:

> "Case management, a practice with little justification, has displayed an astonishing ability to flourish in an age of evidence-based medicine" (p.524).

More detailed evidence related to this issue is examined in section 1.5.

1.3.6. Post community care? - the modernisation agenda

From the time of the accession of the Labour Government in May, 1997, there emerged a change in the vocabulary of health and social care policy. "Community care" and "case/care management", as

terms, were less in evidence, though this did not imply that the concepts and ideas behind them necessarily disappeared overnight. Rather, it may be argued that they survived within a different rhetoric, and the following examination of the more recent literature will test this view.

With major criticisms and doubts surrounding the ability of policy ideals, based on a needs-led service, to be matched by reality, "New Labour" issued a White Paper on the National Health Service (DoH, 1997) announcing the abolition of the internal market, now seen to lead to divisive and fragmented services, and its replacement by "integrated care" (DoH, 1997, para.1.3), based on partnership. Among the proposed changes was the development of local Health Improvement Programmes (HIPs) by all those agencies charged with planning and providing health and social care services, and the formation (in England) from April 1999 of local Primary Care Groups (PCGs), with GP and community nurse representation, charged with responsibility, devolved from Health Authorities, for commissioning health care at a local level. It was envisaged that, in due course, PCGs would apply for trust status, becoming responsible for the provision, as well as the commissioning, of health care. The White Paper was followed up three years later by the NHS Plan (DoH 2000), a document promising significantly increased investment in the NHS, including an extra 20,000 nurses, with greater opportunity to extend their roles, and the creation of care trusts out of pooled health and social care resources, which would enable the commissioning of care by a single organization.

These new developments raised two major issues in terms of the durability of case management in general, and community nurse case management in particular: the organization of budgets and resource control, on the one hand, and the effectiveness of interagency working on the other. Firstly, the potential commissioning role of community nurses was largely welcomed. The fact that the presence of nurses on PCG boards was mandatory prompted an enthusiastic response from community nursing organisations, with the Royal College of Nursing (RCN) commenting that the White Paper (DoH, 1997) "puts community nurses firmly in the driving seat" (Young, 1998, p.8) and

that "the time has come for community nurses to bring their skills, knowledge and experience to health commissioning" (p.9). With this in mind, the organization produced guidance, identifying the skills and knowledge community nurses needed for their new commissioning roles (RCN, 1998b). Similarly, the Community and District Nursing Association (CDNA) encouraged its members to "lay hold of the golden opportunity for our profession to take a central part in identifying local need and commissioning services" (Ballard, 1998, p.4) and produced its own guidance to that end (CDNA, undated).

At face value, it would appear that the increased involvement of nurses in the PCG/commissioning arena would also strengthen their role in case management, where one of the central roles of the Government-preferred entrepreneurship model is, as previously noted (section 1.1.3), that of purchaser. However, this may be an over simplistic view. Kaufman (1998) has cited a number of potential restraining forces which may hinder nurses in this role, including the lack of specialist knowledge and skills in financial management, resource allocation and marketing, which would be a prerequisite for entrepreneurial case management. More importantly, Kaufman (1998) has pointed out that "commissioning is a strategic activity" (p.35), indicating, as did Antrobus (1999), that PCG nurses would be focusing on collective health needs of populations, rather than on the individual focus of case management. Further, Santry and Clark (1999) found the selection process for PCG board membership in one English region favoured service managers over nurses directly involved in primary care, who would be more likely to be in the case management role.

The second, and related issue emerging from the new reforms, and a feature of effective case management, is that of interagency collaboration (including joint commissioning) to produce "joined-up health care" (Primary Nursing Care, 1999, p.5). The need for integrated care was also stressed in the White Paper on Social Services (DoH, 1998a) and would involve partnerships between community nurses, GPs and also Local Authorities, in what Klein (1998) has described as "in effect, managed care organizations" (p. 27), already noted to have affinities with case management in North

America (section 1.2.4), where the responsibilities and roles of nurses have been widened. Rummery (1998) found, in research conducted even before the publication of the 1997 White Paper (DoH, 1997), that successful models of joint commissioning already existed, based on either the locality/area, practice, or individuals. This latter was found to be the most common model and allowed for members of the Primary Health Care team to "carry out some of the assessment and case management functions themselves" (p.433). This practice was obviously supported by the Government's own Partnership in Action discussion document (DoH, 1998b), which included examples of good practice in joint commissioning, where case managers were described as being drawn from social or health services (which included community nurses) and where there was also a clear separation of case management and service management roles. It was also largely supported, along with the enabling legislation - the Health Act 1999 - by the nursing profession and its commentators. Examples of good partnership practices appeared in the nursing press to illustrate the new flexibility, which would enable nurses to work for social service departments without losing their professional identity - an issue for many nurse case managers under the old legislative framework.

Thus, again, it would appear that problematical issues which had hindered the development of nurse case management were being resolved. However, notes of caution were also being sounded; George (1998), for example, while welcoming the proposals, commented that "the Berlin Wall has still not come down" (p.13), while Rummery (1998), notwithstanding the positive practices found within her research, noted a number of barriers to primary care level joint commissioning, and found a major frustration for both front line professionals and service users was the failure to coordinate the planning and providing of services on the ground. Meanwhile, Klein (1998) warned prophetically that "the door of opportunity opened up by the White Paper may, therefore, slam shut unless the nursing profession acts quickly and assertively" (p.27).

However, as within the initial community care legislation, it is, perhaps the mental health field that provides the most complex outworking of the "modernisation" agenda, in view of its separate

legislative and policy framework. The White Paper on modernising mental health services (DoH, 1999a), while stating surprisingly explicitly that "community care has failed" (p.29), continued to reaffirm, within its new vision for integrated care focused on individual needs, that "the principles of care management and the Care Programme Approach (CPA) are an important part of the Government's strategy" and included thorough assessment and coordination by a "key worker" (p.46). However, unlike the impression given in the Partnership in Action agenda (DoH, 1998b), it appeared that, while the CPA was seen as a health responsibility, case management was described as being within the domain of Local Authority social service departments (though a promise to work towards integration of the two concepts may have aimed to lessen this distinction).

Reaction to the proposed mental health legislation was one of muted optimism. One commentator (Wood, 1999) agreed with the sentiments about community care being discredited, but prefaced support for the proposals with the point that one criticism levelled against the policies of the current Government was that they simply "repackaged versions of strategies developed previously by the Conservatives" (p.44). However, Wood (1999) also saw an enabling opportunity for case management and the CPA to be integrated, to allow "coordinators" (p.45) to arrange packages of care, and suggested that "this type of care management should be linked to a form of assertive outreach ... to provide intensive community support" (p.45). A number of pilot schemes of effective mental health care were cited in support of these proposals, as, indeed, was the case with the appearance of the National Service Framework for Mental Health (DoH, 1999b), which also proposed better integration of the CPA and case management. McMillan (2000), for example, cited a unified approach to mental health in Somerset, where staff who formerly worked within social service departments or one of the two National Health Service trusts, now worked in partnership.

Overall, the policy of "New Labour" represented an apparent shift in direction regarding community and primary health care. But, while there was acknowledgement that some of the older legislation was not

working, its new proposals appeared to embrace, even if not explicitly, the ideals of case management and its continuation, albeit under a different guise. In particular, the Government's proposals for community mental health, and for other ways of developing and expanding the nursing contribution - for example the new Primary Care Act pilots (DoH/NHSE, 1997) - certainly made this possible. Like the Audit Commission's (1999) recommendations for the reform of the district nursing service, integration and flexibility of care provision - issues which had been a prominent feature over the history of nursing case management and its literature - were likely to become much easier.

1.3.7. Summary

This section further addresses the first aim of the review.

• The UK social policy context in the late 1980s and early 1990s displayed many of the characteristics of the North American scene prior to the introduction of community care and case management (for example deinstitutionalization, concern for certain client groups, cost containment and service fragmentation).

• The literature covering community care in the UK can be categorized according to its source and timing. "Official" (Government sponsored) literature was often inconsistent in its pre-implementation guidance, but generally positive in its (post-implementation) monitoring. Independent literature was often more cynical in its approach to implementation and critical over specific issues based on experience of implementation and, later, research.

• Concern over "implementation deficit" (Trnobranski, 1995) - the failure of practice to match up to policy ideals - was, to some extent, borne out in the evidence. This occurred in a number of different areas including resources/funding, user involvement and choice, interagency collaboration, models of case management, levels of responsibility (national/local/individual) and levels of focus (community/individual).

• The role of community nurses within community care was unclear and the profession displayed reactions ranging from pessimism to optimism.

• With the change of Government in 1997, community care and case management appeared to be dropped from the policy vocabulary. However, new legislation also promoted those values conducive to both case management and the development of community nursing which had hindered progress in the past.

1.4 Case management, nursing and professional issues

1.4.1 Introduction to section

Any debate about the compatibility between nursing and a related construct may be addressed through a comparative analysis of the two sets of ideals and practices along certain parameters. This section will review literature on the nature of nursing in terms of: theory and practice development; systems and processes; values and hallmarks; tasks and skills; and professional issues. This corresponds, in part at least, to the ways case management may be analyzed, as identified at 1.1.3. Consensus evidence will then be compared with that relating to case management as discussed in the previous section, and thus form some conclusion regarding the potential for the one to inform and advance the other.

1.4.2 Theory and practice development

Much literature on theory development refers to the complexity of nursing (Bower 1992, RCN 1993a) and to the relative "invisibility" of its practice (Ong 1991, Wright 1995) making it difficult both to define and to analyse. Millard (1995) has ascribed this to the fact that nursing has no specific knowledge base of its own, though the fact that it draws from many disciplines may also be seen as a strength, making it more responsive and adaptable to change. Millard's view is at least partially shared by others. Indeed, contextual change has been seen in much of the literature as one of the most influential features of recent years to shape the way nursing has evolved (DoH Nursing

Division 1989, NHSE 1993, CNOs 1993, Joint Committee 1997, Kitson 1997a, Luker 1997).

However, the extent to which Millards's optimism about nursing's evolution is shared varies and reflects both authorship, in terms of professional orientation (management, practice, academic, specialism) and also possible "hidden agendas". One stance is illustrated in the spate of national publications from the time of the NHS and community care changes, and emanating either from the government or the profession itself, which painted an extremely positive, forward-looking picture. This is evident in the rhetoric of publication titles and language: "New World, New Opportunities" in an "exciting" future (NHSE, 1993); a "Vision for the Future" of how nurses can contribute to the "challenging" agenda for the future (NHSME, 1993); a call to "shape" the future (CNOs 1993 - the so-called "Heathrow Debate") and a "Celebration of Nursing" (Joint Committee, 1997). Although these publications often listed what was considered to be central characteristics or components of nursing, there was little attempt to engage in any theoretical debate, and Wright (1994) has commented on the charge levelled against one of these (NHSME, 1993) that it was too political and concerned with the government's, rather than a nursing, agenda.

Another stance is illustrated in the number of nurse academics and professionals who have offered more analytical commentaries on the development of nursing, both in the past and for the future. Luker (1997) has dated the development of the conceptual origins of nursing from the early 1970s, when academic departments of nursing began to be influenced (as was case management) by ideas and theorists from North America. This led to a "plethora of nursing theories" (p. 261), with a mission to identify the unique function of the nurse. Lea and Watson (1996) saw these in terms of a quantitative/qualitative continuum of theories, ranging from that of Watson (1988), taking an extreme existentialist position, which argues for a holistic approach, through Leininger (1981) and Orem (1980), to Gaut (1983), who took a reductionist view that nursing care could be broken down to behavioural tasks and thus analyzed.

The academic debate has tended to polarize around the extremes of the continuum and the related issues of who should, in fact, define nursing and which disciplines and subjects it should encompass. All of these debates provide some insight as to how nursing may relate to case management. Many nurses today (for example Rolfe, 1997) support the view of Benner (1984), who argued that theory should be derived from, and also inform, practice and experience. Indeed, there is no shortage of recent work endeavouring to uncover the nature of nursing knowledge or nursing expertise using just this approach (for example Lawler, 1991, Cutliffe, 1997). This argument that nursing is defined in terms of whatever it means to individual practitioners could, of course, *de facto* easily accommodate case management practices, but it is also this line of reasoning which Bradshaw (1995) has taken issue with in a critique of the phenomenological approach. Bradshaw argued that this paradigm, no less than the rationalist-empirical tradition , which has historically characterized nursing theory (Nolan and Chung, 1996), relies on hidden assumptions based on a supposedly universal "common sense" view of nursing. But such polarization is, perhaps, as unhelpful as the existence of Luker's (1997) "plethora of theories", and Brykczynska (1993) has suggested that nursing should re-examine the values of its past to see what is good and worth retaining, and what needs to be modified or abandoned. This resonates with Millard's (1995) comments on nursing's adaptability and would certainly make the assuming of new practices (such as case management) more acceptable.

The related issue of underlying disciplinary theory has also changed over nursing's history. A foundation in "moral principles, religion and common sense" (Nolan and Chung, 1996, p. 46) has been replaced by an allegiance to scientific principles, though the question of which sciences should receive prominence continues to be hotly debated. Luker (1997) commented on the preponderance of psychological and physiological, rather than sociological, theories, though Lawler (1991) appeared to feel that sociology was over-represented and adopted an inappropriate "macro-level" focus. While it would seem to be true that the behavioural sciences have, in recent years, replaced an emphasis on the medical model, there is now concern that the biological sciences have been marginalized and should be reclaimed

as central to nursing theory (Torrance and Jordan, 1995). Either way, a basis of scientific theory would equip practitioners for case management if adopting an "intensive" or "clinical" model, though a "micro" level approach has more in common with the case management focus. The adoption of a more administrative model of case management may be open to question.

Finally, the issue of who should define nursing is also one of relevance here, as it appears this has not always been nurses themselves. Nolan and Chung (1996) have commented, in examining changes in mental health nursing, that, historically, nurses have had their work defined for them (largely by the medical profession, but also a range of other interested parties). Wright's (1994) observation that "Vision for the Future" (NHSME, 1993) has been held by some to be, like case management, largely politically influenced, suggests this is still the case, though Wright also made the comment that the document was produced with a "fair degree of consultation with nurses" (p.31). However, a greater volume of theoretical literature has emanated from the hands of individual (again, largely North American) nurse academics (for example Henderson 1969, Rogers 1970, Roy 1980, Orem 1980) though, because they tended to deal with broad theories, rather than the particulars of nursing, these neither prescribe nor prohibit the adoption of new ways of working such as case management.

But a more recent trend is to value the views of those closest to practice itself - individual practitioners and even clients - in the construction of nursing theory, while, at the same time, aiming for a systematic body of knowledge. Nolan and Chung (1996) have suggested that today nurses have a greater opportunity to challenge the scientific bases of care and certainly the use of practitioner focus groups in order to achieve consensus statements is growing in popularity (Miller et al, 1996), while the views of clients are often featured in such undertakings (Ong, 1991, Miller et al, 1996). Yet there is also an impetus to underpin nursing theory with research, evidence-based practice and clinical effectiveness (Kitson, 1997), in other words, basing clinical decisions on scientific precedent and "what works", rather than opinion, however well argued. This being

the case, it is important to examine the effectiveness of new roles and practices, such as case management, as well as whether they appear to be in keeping with nursing ideals. This will be the focus of the next section.

For the current debate, it would seem that a multi-perspective on nursing is needed, since, firstly, a single viewpoint will not always find agreement in others (for example clients and practitioners), secondly, values are not universal to all specialisms and, thirdly, ideals may be out of touch with actual practice (Bergen, 1999). However, there does seem to be general agreement on the need for nursing to adapt to changing contexts. As Sullivan (1998) has said:

> "A profession that fails to change its values and holds on to tradition and routine in the face of developing technologies, more knowlege, increased information and rising expectations, is a profession that is unlikely to survive in any recognisable form in the 21st century" (Sullivan, 1998, p. 38).

1.4.3 Systems and processes

The extent to which a profession can change and adapt depends, in no small measure, on the degree to which the system within which it functions is conducive to such change. A review of the literature suggests that nursing and case management, which are both essentially care processes, can operate effectively and mutually where professionals themselves are able to take control of these organizational systems and thus ensure practice equates to its ideals and objectives.

Nursing has, for some 20 years, been seen in terms of a process, defined by its practitioners (Cowell and Swiers 1997, Walsh 1997). It has further been suggested (section 1.2.4) that, while case management has been variously regarded as a service, programme, role, system or technology, it, too, can most helpfully be seen as a process. In both cases, however, autonomy is limited by the overarching organizational characteristics. Clifford (1995) has commented that nurses must acknowledge that they are paid for what

they do and are subject to the controls imposed by the health care system. The point was also made by Savage (1995), with regard to local conditions, and Smith (1992) at the individual level. The extent to which case management has been similarly subject to policy dictates has been discussed at some length in the previous section of this review (section 1.3). Conversely, it has been noted, both in nursing (Bond 1993, Rodgers and Fry 1994, Morrish et al 1995) and case management (section 1.2.4), that it is important that appropriate structures and support are in place in order to ensure successful implementation.

There is a wealth of literature testifying to the conflict which may occur between organizational constraints (such as high workload, poor management, cost containment) and ideal nursing practices (Smith 1992, Perry 1993, Wade 1995, Kitson 1997a, Luker 1997). Again, the parallel tensions between case management ideals and government policy have already been noted (section 1.3). But Kitson (1997a) has suggested that nurses may rise above these constraints by taking control of nursing systems and must be involved at every level of decision making in health care, from strategic planning at national and international level to local groups. Her viewpoint would appear to be supported in other nursing literature, which advocates the active adoption of processes and new ways of working, which either rise above externally imposed constraints, or work within them through a new interpretation of the nursing role, without betraying its fundamental ideals. A number of these have been concerned with case management practices.

One example of this literature is the work on primary nursing. Wright (1994) and Luker (1997) have both suggested primary nursing as a vehicle through which the government-imposed "named nurse" initiative (DoH Nursing Division, 1989) can be implemented. Further, a number of writers (Ford and Ryan 1992, Hancock 1992, Bond 1993, Waterman et al 1996) have detected similarities, as have some North American commentators (Knollmueller, 1989), between this mode of practice and case management, seeing the latter as but a logical extension of the former. In some literature the discussion has broadened out, commending the replacement of outmoded systems

with alternative, multidisciplinary systems, which may facilitate case management. These include managed care (Hancock 1992, Walsh 1997, RCN 1997) and critical/recovery/care pathways (Barrett 1994, Walsh 1997), both of which have been previously discussed in the North American literature (section 1.2.4)

But, although nursing (and particularly primary nursing) as a process would appear to have an allegiance with case management, there have been notes of caution sounded, which may impact upon its general uptake in practice. Bond et al (1991) have commented on the lack of clarity surrounding the term "primary nursing", which may be seen as both a philosophy and an organizational design. In particular, these authors have questioned whether it is an all-or-nothing concept, or one which can be dissected into different dimensions, reflecting a difficulty which has, of course, been observed in the interpretation of case management and its dimensions (table 1.2). This would make the implementation of either problematical. A further point has been made by Lyon (1993), whose review and analysis of the case management and primary nursing literature in North America noted distinct differences between the two. The main issue, and one not without significance in a "caring profession", is that direct patient care does not fit in with the traditional definition of case management. This issue will be further explored below.

1.4.4 Values and hallmarks

Cox (1993) has argued that values should determine practice and there have been many attempts to define what is variously termed the nursing constant (CNOs 1993, RCN 1993, Kitson, 1997a), cardinal or basic principles (DoH Nursing Division 1989, NHSE 1993) or core values (Joint Committee, 1997). Some definitions, such as those of Henderson (1969) or the definition of district nursing given in the 1977 letter from the Chief Nursing Officer (CNO, 1977), have stood the test of time and support the theory of constancy. But Cox (1993) also suggested that nursing values should adopt a teleological position - the theory that it is consequences which should dictate whether an action is right or wrong, rather than Kant's "categorical imperative",

which classifies actions more by intrinsic characteristics. In other words, values and principles may change, a factor which may yet mitigate problems like that mentioned above of the direct patient care element of nursing being incompatible with case management. This tendency to change can be illustrated in a number of ways in nursing.

One such way is the move over time from an emphasis on discrete tasks as the defining characteristic of nursing, to a focus on whole aspects of care, or holism, embodied in the so-called new nursing (Bradshaw 1995, Clifford 1995, Kitson 1997a, Luker 1997). This principle, too, may be subject to change; Ong (1991) has questioned the universal appropriateness of holistic care, while Luker (1997) has suggested that it may no longer be affordable in the current NHS climate of cost-efficiency, heralding a return to task orientation. Further, Wright (1995) has been prompted to ask whether there is now such a thing as "basic nursing", commenting on the way that "real" nursing is currently associated less with the fundamental caring skills than with acute, scientific, medical intervention. Other examples of changing emphases are the debate over whether nursing should focus on meeting needs primarily of individuals or populations (RCN 1995, Luker 1997), and whether it should care primarily for the ill (Torrance & Jordan, 1995) or the well also (CNOs 1993).

It would seem, then that, as Warr et al (1998) have observed, there is no single enduring model of what constitutes nursing. However, like theory development, this absence of rigid frameworks could be said to facilitate the flexibility which allows the adoption of new roles and innovative approaches. Some of the more commonly cited of these diverse values and hallmarks of nursing are listed in table 1.2 and may illustrate its potential degree of adaptability to the essence of case management.

One general comment to make based on this evidence is that there appears to be no intrinsic reason why nurses may not act as case managers, though there may be differences in emphases between the two practices, such as the more overt inclusion of social care and social service orientation in case management and its greater focus on the individual and on cost-efficiency, with a lesser focus on therapy.

Table 1.2 Comparison of nursing and case management values

Nursing values and hallmarks	Examples from the literature	Comparative features of case management	See previous review sections
Definition: Nursing as caring/professional caring/formalized caring	Lipsky 1980, DoH Nursing Division 1989, CNOs 1993, Traynor 1993, Clifford 1995	About the management of care ("care management")	1.1.3, 1.3.5
Aim: Promoting/improving health and independence	Henderson 1969, DoH Nursing Division 1989, NHSE 1993, Joint Committee 1997	Usually concerned with social, as well as health care. More explicit aim of cost efficiency	1.2.3, 1.2.6
Client groups targeted: Individuals/families/populations; carers/relatives; ill & well/frail & vulnerable, including long term care of those with complex needs; all settings	Henderson 1969, Lipsky 1980, Ethridge & Lamb 1989, CNOs 1993, NHSE 1993, Traynor 1993, CDNA 1995a, RCN 1995, Torrance & Jordan 1995, Joint Committee 1997, Walsh 1997	Focus largely on the individual (the "case") with complex health and social needs. Largely community setting (in UK)	1.1.3, 1.2.4, 1.2.5, 1.3.5
Nurse/patient relationship: Holistic, therapeutic, based on named nurse, a sustained encounter, a mutual endeavour, emotional, relationship centred	Ong 1991, Bond et al 1991, Morse et al 1992, NHSE 1993, Traynor 1993, Wallum 1995, Bergen et al 1996, Cutliffe 1997, Dawber 1997, Kelly 1997	Holistic assessment, named individual or team, may include therapeutic dimension (depending on model eg primary therapist, clinical case management)	1.1.3, 1.2.5, 1.3.5,
Client centred values: Patient centred orientation, dignity, individual need, choice, consumer views, empowerment, confidentiality, continuity	DoH Nursing Division 1989, Bond et al 1991, Repper & Peacham 1991, NHSE 1993, Millard 1995, Cutliffe 1997, Joint Committee 1997	Definite client centred values	1.1.3, 1.3.5
Professional values: Accountability, nurse-led, collaboration, teamwork; evidence/research-based, value-for-money, quality assurance, practice development; policy and purchasing contribution at all levels; professional development and supervision	DoH Nursing Division 1989, CNOs 1993, NHSE 1993, Joint Committee 1997; DoH Nursing Division 1989, NHSME 1993, NHSE 1993, Joint Committee 1997; DoH Nursing Division 1989, NHSME 1993, Joint Committee 97; NHSME 1993, Joint Committee 1997	Some professional values beginning to emerge (leadership, collaboration & teamwork, coordination, supervision). Others (research base, preparation, quality assurance) not yet fully developed	1.1.3, 1.2.3, 1.2.6, 1.3.5
Service values: Accessibility, availability, primary health care led	Ethridge & Lamb 1989, NHSE 1993, Joint Committee 1997	Tendency to be social services-led in UK. Availability/accessibility dependent on local criteria	1.2.3, 1.3.5

However, the aims, client groups, and the client, professional and service values and orientations share much mutual ground. It is particularly worth noting that nursing is now setting greater value on its focus (as with case management) on long term care of the elderly (RCN, 1993a), those with enduring mental health problems (Sullivan, 1998) and those with complex learning disabilities (Sines, 1991).

One issue which may militate against the assumption by nurses of case management, at least in name, is the long-standing allegiance to the title "nurse". Although the NHSME Value for Money Unit (1992) used the title care manager to describe the "G" grade community practitioner in an ideal skill-mix, Bentley (1993) has taken issue with this usage, feeling it would lead to confusion, being a title also used by social service workers.

However, the CDNA (1995b) has noted what it considers to be an obsession with titles and labels, which has given rise to confusion (for example, between nurse practitioner and specialist and advanced practitioner). A survey by Carey (1995) revealed similar confusion but found little difference in practice. Certainly practising nurses themselves seem less precious about the title, at least in mental health, where the term "key worker" or "practitioner" is often preferred, irrespective of professional orientation (May, 1996). Indeed, there would seem to be support from many quarters for the idea of nurses being well suited to the case manager role from the perspective of its ideals and values. Sources of this support are detailed in table 1.3.

1.4.5 Tasks and skills

Despite a general agreement that nursing is ideologically compatible with case management, it must be acknowledged that some notes of caution have been sounded (for example George 1993b, Thomas 1994, Sisson 1995), raising the question of whether such ideals can be translated into practice. Indeed, the problem of the ideals-practice gap has been well documented (Lipsky, 1980). One way of analyzing nursing/case management compatibility at the practice

level is to look more closely at the tasks and skills of nursing and to compare these with the core stages of case management as outlined at 1.1.3.

Table 1.3 Literature supporting compatibility between aspects of nursing and case management

Source	Aspect or perspective of nursing compatible with case management
Alderman 1993	Cross training/patient focused hospitals
Barrett 1994	Use of recovery pathways
Bond 1993	Primary nursing
Bower 1992	General nursing
Brittian 1992	Community nurses, esp district nurses and HVs
Brown 1989	Occupational health nursing
Cohen & Cesta 1993	Managed care
Cronin & Maklebust 1989	Clinical nurse specialist
Currie & Harvey 1998	Primary nursing/use of care pathways
Dawber 1997	Mental health nursing
Ethridge & Lamb 1989	Professional nursing
Ford & Ryan 1992	Multidisciplinary work, nursing process, primary nursing
Gournay 1992	Mental health nursing
Hancock 1992	Primary nursing
Hatfield & Mohamad 1996	Mental health support workers
Holzemer 1992	Use of Orem's model
Hudson 1991	Community learning disability teams
Kemp & Richardson 1994	Hospital/community interface eg district nurses
Knollmueller 1989	Primary nursing
Laurent 1993	General nursing
Millard 1995	Practice nursing
Noble 1998	Parkinsons Disease nurse specialist
Petryshen & Petryshen 1992	Hospital nursing
RCN 1997	Clinical nurse specialist
Repper & Peacham 1991	Mental health nursing
Rogers 1998	Practice nursing
Ryndes 1989	Nurses' service knowledge
Sandford 1995	Mental health nursing
Sines 1991	Learning disability nursing
Sisson 1995	District nursing
Thomas 1994	Nurse purchasers
Wood 1991	Elderly care nursing
Worley 1991b	Nursing process

This is not a simple undertaking; firstly, it must be said that, while case management may sometimes be seen in terms of a set of functions (Bower, 1992), nursing is usually considered to be more than this (RCN 1993a, 1995). Furthermore, there is a degree of overlap between what may be regarded as nursing skills and what is seen as its values and hallmarks (for example its health promoting aim, the therapeutic relationship, multidisciplinary collaboration/

teamwork and purchasing). Finally, as already noted in discussing values, differences of opinion exist within the profession as to what skills and tasks legitimately fall within the nursing remit.

In view of these difficulties, a helpful framework within which to analyze the literature may be the stages of the nursing process which, as Worley (1991b) has pointed out, are not dissimilar to the stages of case management. Skills and tasks will therefore be discussed under the general themes of targeting and assessmment; care planning; care delivery (including the issues of advocacy, collaboration, management and purchasing) and evaluation.

Targeting those eligible for services has been described as a case management function (section 1.1.3) but is, perhaps, less of a feature of nursing literature. Hudson (1991) has described a "gatekeeping" role for community learning disability nurses, while the RCN (1995) saw the identification of priority groups and individuals as a function of the community health care nurse. But the related, pro-active searching for health needs, which is a characteristic of health visiting practice (Chalmers, 1992) has not been found to be so prominent in district nursing (Worth et al, 1995).

Assessment has been almost universally accepted as a major skill in nursing since at least the time of the 1977 letter from the Chief Nursing Officer (CNO, 1977). It is certainly a component of the role of the primary or community health care nurse (NHSE 1993, RCN 1995), district nurse (NHSME Value for Money Unit 1992, Ross and Bower 1995) and nurse practitioner (Carey 1995, Briggs 1997), though there may be differences in the interpretation of what assessment entails (for example the nurse practitioner assessment includes an element of physical examination and diagnosis). There is some evidence of nursing assessment moving towards a case management model in the light of community care changes. These include examples of assessment of elderly people for nursing home placement (Gilbert 1993, RCN 1998a), joint assessment (Korczak, 1993), nurses as lead assessors (Carlisle, 1992) and nurses as financial assessors (Knollmueller 1989, Kelly 1997). Assessment protocols and tools are also often locally determined (Ross and

Bower, 1995). However, there is also evidence of difficulty in maintaining the holistic ethos in the reality of community nursing (Ong, 1991) and in seeing assessment as a separate (from provision) entity as envisaged in the community care legislation (Bergen et al, 1996). Kelly (1997) also felt that responsibility by nurses for financial assessment had a negative impact on the therapeutic relationship.

Care planning, though generally accepted as a nursing skill (Ethridge and Lamb 1989, Hancock 1992, Cowell and Swiers 1997) is less well documented in the literature. However, the Heathrow Debate (CNOs, 1993) described a role for nurses in the development of "programmes of care", while Ovretveit and Davies (1989) also turned to different terminology, referring to the work of learning disability nurses with individual programme plans. The essence is probably the same, and certainly reminiscent of the case management vocabulary, though Wallum (1995) found that care plans were not generally read or used effectively in nursing.

Care delivery is becoming perhaps the most contentious debating ground in nursing, as it is in case management. Traditional definitions of nursing tended to see the profession in terms of various aspects of the care provided. For example Henderson (1969) emphasized activities of promoting health, recovery, independence and rehabilitation, and preventing ill-health. More recent literature has seen these activities as only a part of the nursing role (NHSE 1993, CNOs 1993, CDNA 1995b, RCN 1996), while others have questioned the need for professionals to be involved in actual therapy at all; Ethridge and Lamb (1989), for example, referred to "activating intervention", implying indirect involvement and Bond (1993) similarly wrote about having responsibility for care while not necessarily being the actual provider. Cronin and Maklebust (1989) felt care delivery to be difficult in combination with a case management role, while the NHSME Value for Money Unit (1992) suggested only the care practitioners, as opposed to "G" grade care managers, should deliver care. Hunter (1988) agreed that nurses are usually service providers and suggested that they may experience difficulty in remaining sufficiently independent to perform an

advocacy role, overplaying the importance of nursing care to the possible exclusion of other necessary support.

Nevertheless, clinical expertise appears to be valued even in the context of some models of case management (Petryshen and Petryshen, 1992) and has been found to be particularly highly rated by patients (Torrance and Jordan, 1995) and nurse practitioners (Briggs, 1997). In addition, a number of more expressive, relationship-centred skills are mentioned in the nursing literature, such as communication (Repper and Peacham 1991, Wright 1995 Cutliffe 1997), teaching (CNOs 1993, Bentley 1993) and counselling (Knollmueller 1989, Repper and Peacham 1991). Torrance and Jordan (1995) found that nurses themselves rated highly these supportive/affective behaviours, somewhat akin to the "presencing" of Benner's (1984) expert nurse (RCN, 1996). Relationship skills are also fundamental to a clinical model of case management (Worley, 1991a).

One function related to service delivery widely held to be a nursing responsibility across specialisms, and also a basic feature of most models of case management, is the coordination of service inputs (Ovretveit and Davies 1989, Ethridge and Lamb 1989, Hudson 1991, Hancock 1992, Kemp and Richardson 1994, Hatfield and Mohamad 1996). The RCN (1993a, 1993b) has suggested that nurses caring for the elderly are ideally placed to be "key networkers", however the evidence suggests that multidisciplinary collaboration has a poor record at the service delivery level (Higgins et al 1995, Sibley 1997), which militates against the implementation of such mandatory functions as joint assessment (Korczak, 1993).

More debatable as a nursing responsibility is the role of advocate. While some commentators have argued this to be within the nursing remit (Thomas 1994, Cutliffe 1997, Joint Committee 1997), others have noted the potential for a conflict of interest here (Dyer 1991, Morrison 1991, Marshall 1991, Sutor 1993) for much the same reasons that it has been seen as problematical in case management (Orme and Glastonbury, 1993). Mallick (1998) found these contradictions reflected in a series of semi-structured interviews with

nurse leaders in the UK, who agreed that advocacy was integral to the moral value system of nursing, but objected to the professionalisation of the role. Further, it has been suggested that the lack of a uniform definition of the concept has given rise to confusion (Bennett, 1999).

Skills in management of both care and people have been more uniformly promoted as essential in a number of nursing specialisms and settings, for example primary health care nursing (NHSE, 1993), district nursing (NHSME Value for Money Unit 1993), learning disability nursing (Ovretveit and Davies, 1989), nurses working in nursing homes (RCN, 1996) and nurse practitioner work (Ong 1995, CDNA 1995b). The managerial emphasis in case management has previously been noted (section 1.3.5.) and expertise here has been seen to suit nurses to this role (Cohen and Cesta, 1993), particularly if adopting a service brokerage model (Worley, 1991a).

It has been suggested above that carrying out financial assessments may not be readily accepted by nurses, a stance which may suggest a similar reluctance to become involved in purchasing strategies (and case management was, of course, emphasized very much as a purchaser function in UK government policy). However, the literature is variable here. Murdock (1995) has commented on the inexperience of mental health nurses in marketing and business planning and Thomas (1994), while suggesting the involvement of nurses in micro-purchasing (as in case management) to be essential, felt that this could be problematical where nurses are employed (as is usual) by providers. However, Mackereth and Wright (1994) and Benton (1995) have seen opportunities for nursing input into purchasing and commissioning, and both the RCN (1997) and Kemp and Richardson (1994) described a legitimate nursing role in the mobilizing and coordination of resources.

Finally, evaluation and monitoring care appear to be assumed aspects of nursing, often quoted as the last stage of nursing process-type skills (CNO 1977, Ethridge and Lamb 1989). More recently there has been a suggestion that nurses should take on an economic evaluation of their work (Gournay and Brooking, 1991). However,

details of evaluation in practice are less well documented and if the "implementation deficit" which Trnobranski (1995) noted in community care is also a feature of nursing, this may account for the lack of detail.

As a post script to the consideration of nursing skills, the issue of educational preparation for their practice perhaps warrants further attention. At the time of writing, community nurses in the UK qualify under the UKCC's guidelines as specialist practitioners at first degree level (UKCC, 1994), while a proposed regulatory framework for higher level practice (HLP) is being pilot tested and validated (UKCC, 2000). Both the skills anticipated for community nursing in the future and the characteristics of HLP (UKCC, 1999) appear compatible with a case management role (in particular a clinical model of case management) and Reveley and Walsh (2000) have implied that this should be incorporated into current BSc level curricula. This is also comparable with the North American advanced level practice/clinical nurse specialist, which has been associated with the case management title, though it appears that preparation for this role is increasingly moving forward to master's level (Cronin and Maklebust 1989, Conger 1999).

1.4.6 Professional issues

A number of hallmarks of professionalism have been noted as increasingly important to nursing and, to a lesser extent, to the present state of case management in the UK. These include accountability, evidence-based practice and research, quality assurance, practice development, policy contribution, professional development and supervision (table 1.2). One professional issue worth exploring in more detail, in view of its importance to the effective functioning of community care in general, and case management in particular, is that of interagency collaboration and the associated definition of professional boundaries.

Much literature of the 1990s has variously described professional boundaries as a "fine line" (Joint Committee, 1997), "blurred division" (Leifer, 1997) or "fluid" (Warr et al, 1998), in view of the

so-called "grey areas" (Carlisle 1992, Higgins et al 1994a) or "overlap" (Gournay, 1992) between health and social care roles. Millard (1995) has described how acting as a case manager felt at times more like social work than her professional district nursing background. There has also been much discussion around the issue of "substitution" of one discipline for another (CNOs, 1993), for example between doctors and nurses (Luker, 1997) and between community psychiatric nurses and approved social workers (Huxley and Kerfoot, 1993). Gournay (1992) has even suggested that mental health nursing may follow the pattern of learning disability nursing, where such overlaps have led to these professionals feeling a need to justify their own existence.

On the other hand, much has been made of the so-called culture gap between different care professionals, which would appear not only to defy the claim to "blurring" of roles, but also to make collaboration less likely. Worth et al (1995) have described how social workers have difficulty in understanding the work of district nurses, while Hudson (1991) has highlighted the differing value systems, priorities and lack of understanding between members of community learning disability teams. In Croydon it was thought necessary to draw up a charter defining the respective responsibilities of nursing and social care staff in the community, since "the interface between social service providers and health providers had all but stopped because of the new care management role" (Brothwood, 1997, p.19). An even more complex picture has been painted by Higgins et al (1994b), who have observed that there is not one health culture and one social service culture, but several, and that a particular health service role might have more in common with social work than another in health. Moreover, Higgins et al (1994b) also claimed that professionalism is differently manifested in health and social care; for example district nurses are trained to encourage independence, while home care staff are trained to "make people comfortable" (p.273). In this light the issue of transferable skills is less easy and, argued Higgins et al (1994b), an occupational therapist background might not be acceptable for a manager of health visiting services. Such a scenario may prove not unlikely in case management.

This issue of interagency relations and differences is important for nurses at a time when the whole subject of professionalism is under debate, if not under threat, and will have a bearing on its readiness to adapt to new roles such as case management, which may not currently be regarded as professions. On the one hand, proponents of professionalism like Rodgers and Fry (1994) have argued that "the ability to practice distinctive professional skills is important to professionals' status, identity and values" (p.26), and Luker (1997) has further argued that "new nursing" itself could be viewed as a professionalization strategy. On the other hand, a number of authorities have argued, like Lipsky (1980), that a model of professionalism is not necessarily the way forward. Shaw (1993) has noted a general thrust in government policy to deregulate areas of professional activity such that membership of a profession will not necessarily mean that an individual satisfies a particular job specification. The advent of NVQs was cited as an example here, posing a threat to related professionals. The dominant cultures of managerialism (Hatfield and Mohamad 1996) and the market (Bovell et al, 1997) have also been seen as de-emphasizing professional codes and values in favour of efficiency and productivity.

Either way a response is called for from nursing and its corporate reaction could indicate how readily it both serves its clients and embraces a case management model of practice in the current climate. A range of such responses has appeared in the literature. At one extreme Rodgers and Fry (1994) have suggested that in times of uncertainty professionals may feel a need to defend their territory, such that the "grey areas" are shunted around at a cost to users. Wright (1995) has commented that "when arguments rage about professional boundaries, it is more often about who has power over whom than which activities are in the best interest of patients" (p.27). Similarly, Worth et al (1995) argued that attempts to assign health and social needs to precise categories does not address the problem of meeting clients' needs which fall at the boundary of health and social care. The point is supported by Sines (1991) in his advocacy of a case management approach to overcome the limitations of such strict demarcation lines. But, given a general feeling of fear of role erosion by some community nurses (Brittian 1992, Morrish

et al 1995) it has been suggested that, together with the financing of health care, there are reasons to suppose it may be difficult for non-social workers to become case managers (Morrish et al, 1995).

A "middle-range" scenario might envisage nurses adapting, albeit reluctantly. The Celebration of Nursing, Midwifery and Health Visiting (Joint Committee, 1997) noted an expansion in the nursing role, even though this was ascribed to pressure from the reduction in junior doctors' hours. Millard's (1995) district nurse-case manager role, referred to above, though viewed with scepticism and fears for their own jobs by colleagues and social workers, also gave rise to optimism in others. The NHSE (1993) further endorsed this optimism in its observation that, though there have been power struggles in the past, these were being replaced by an approach to care based on ongoing interprofessional respect and understanding.

Finally, at the opposite extreme of the range of responses there exist several examples of change and role development which may well accommodate case management. The difficulty in changing practice brought about by the need for certificates in order to extend nursing skills (Briggs, 1997) has been much ameliorated through the enabling Scope of Professional Practice (UKCC, 1992a) which has, to a certain extent, "legitimized substitution" (Luker, 1997, p.264). Repper and Peacham (1991) have posed the question of whether nursing skills are, in any case, a professional monopoly, while Benton (1995) has suggested the way forward to be in relinquishing highly specialized roles in favour of the generalist role, in order to reclaim holism. A logical extension of this may be the hybrid social service/health worker which Carlisle (1992) has predicted will evolve to meet complex needs. Much literature in the UK, as well as North America, has focused on the need to invest resources into educating nurses to take on the case management role (Intagliata 1982, Cronin and Maklebust 1989, Bower 1992, Kemp and Richardson 1994, Hatfield and Mohamad 1996) and Millard (1995) has suggested there needs to be a recognized course and qualification for case managers to protect the professional integrity of those from a wide variety of professional backgrounds.

So it appears that nursing has at least the potential to adapt and transcend professional boundaries, though there are indicators, too, that it is concerned not to relinquish its enduring hallmarks from the past. As Leifer (1997) has said: "there will be people called nurses walking around wards in 20 years time, but there will also be people called nurses doing lots of other things as well" (p.20). This may augur well for potential nurse case managers.

1.4.7 Summary

This section addresses the second aim of the review. Nursing, as both theory and practice, is difficult to define, though definitions of its essence have been attempted by policy makers and academics. Arguments for its potential compatibility with case management may be both supported and rejected in the literature on a number of grounds (see table 1.2). If nursing is to embrace the case management role, the way forward appears to be best served where nurses are able to take control of organizational systems, thus promoting a match between ideals and objectives, and also where professional boundaries are transcended without relinquishing the traditional hallmarks of nursing.

1.5. UK community case management projects and research

1.5.1 Introduction to section

Despite the argument for at least a potential compatibility between nursing and case management in both theory and practice, it was also suggested at the start of this review that the usefulness of any model of care will further be influenced by its ability to benefit patients and clients. In other words, research evidence should point towards clinical effectiveness, in addition to "best practice" in terms of process and implementation issues.

Reviews of the world literature (mostly North American based) on case management suggest, however, that it is lacking in consensus regarding outcomes, is difficult to assess comparatively, and has dubious applicability outside the research setting (see section 1.2.6).

Marshall (1996), for example, has reported that, while twelve of the thirteen randomised controlled trials (RCTs) of "assertive" case management he located found it to be beneficial compared to routine care, all but one of the trials of "standard" case management he found had negative findings. On this basis Marshall (1996) questioned the way British community care policy has become biased towards this model of care. Kemper et al (1987), meanwhile, in a discussion of different methods of researching case management across sixteen North American demonstration projects, noted the difficulties in comparing across even the RCTs he described (largely because of finding suitable outcome measures). Poor conceptual outcomes was also one reason ascribed by Ryan et al (1991) to the difficulty of assessing research in this area. Further, these authors commented on the abundance of "no change" outcomes as a result of using traditional medical expectations inappropriately for long term patients. Other factors they noted include: poor descriptions of studies, the variety of case management models used and problems isolating the effects of case management in those for which it formed only one element of change.

Clearly there is a need, not only for further research, as Intagliata (1982) has suggested, but also for reviews to be more locally based. Notwithstanding the difficulties enumerated above, this section will analyse a selection of British case management project evaluations, in order to further these aims. Although selection has majored on the larger, better known projects, for their comprehensive coverage, a small number of lesser, "mainstream" projects have been included for the additional light they cast. The section will be prefaced by a consideration of previous reviews of such literature.

1.5.2 Previous reviews

Nine reviews of case management in the UK between 1988 and 1996 were located, which varied in focus, detail and coverage (table 1.4). These were mainly written as reviews in their own right, though some constituted prefaces to, and/or included, the author's own research (Dant et al 1989, Pilling 1992, Challis 1994b).

Table 1.4 Previous reviews of case management in the UK (1)

Source	Client group(s)	Approach	Projects reviewed
Hunter 1988	Physical handicap	Detailed review of 3 King's Fund projects and brief review of others	King's Fund projects: Camden & Islington, Westminster & Kensington & Chelsea, St. Bartholomew's.
Dant et al 1989	Elderly & physical disability	Detailed review of 3 projects.	Kent, Camden & Islington, Gloucester
Beardshaw 1990	Elderly	Analysis of projects to identify common themes	Kent, Darlington.
Beardshaw & Towell 1990	All	As above	Kent, Darlington, Camden & Islington, Gloucester, Winchester (Andover).
Hudson 1992	Elderly & learning disability	Review of 4 British case management projects comparing processes with policy guidance	Kent, Gateshead, Darlington, Wakefield.
Pilling 1992	All	Reviewed by model with each project discussed under structured headings	Independent brokerage/advocacy: Camden & Islington, CHOICE, Resource Worker, Archway, Bristol. Service brokerage type: Lifestyles, Herefordshire. Quasi-independent: PROFILE, Wakefield. Head injuries: St. Bartholomew's, N. Bedfordshire. Therapeutic: Salford, Southampton, RDP programme, Westminster & Kensington & Chelsea, Gloucester. Resource control: Kent, Gateshead, Darlington, Lewisham, Canterbury, Andover. Independent resource management: Guy's/Age Concern (Ipswich/Newham), Care in the Community. New developments: MAIN.

Table 1.4 (cont) Previous reviews of case management in the UK (2)

Source	Client group(s)	Approach	Projects reviewed
Ritchie 1992	Mainly mental health	Compared 3 mental health projects (in detail) with 2 local authority projects (less detail)	Mental health: Cambridge, Nottingham, Paddington. Local authority: Kent, Bromley.
Challis 1994b	All	Reviewed by client group and discussion of emerging issues	Elderly: Kent, Gateshead, Darlington, EPIC, Gloucester, Ipswich & Newham. Learning Disability: Andover, Wakefield, Maidstone. Physical disability: CHOICE, Resource Worker Mental health: RDP projects.
Phillips & Penhale 1996	Elderly	Multi-author chapters on issues relevant to care management	PSSRU projects: Kent, Gateshead, Darlington. Scotland: EPIC, Tayside, Fife, Central & Borders.

Research in this area appears to have been slow to develop. Pilling commented in a relatively early (1992) review that there was very little published material on the "experimental" case management projects in the UK, while by 1994 Challis (1994b) was still making reference to the relative newness of much of the work. However, by 1996, Phillips and Penhale were able to detect three waves in the literature: the early publications on the topic, mainly from the PSSRU, with an academic focus; the Department of Health literature, concerning implementation of case management arrangements; and the more critical literature, focusing on the difficulty of applying theory to practice.

Challis (1994b) felt that, ideally, studies subject to review should provide information about model of case management, operational/clinical processes, outcome and costs, though it was not always possible to use such stringent criteria. A number of the reviewers have commented on these issues across the research. Beardshaw and Towell (1990) found that models of case management were not distinct in practice, but a number of "process" themes emerged. These included interprofessional rivalries (also noted by Pilling, 1992) and the process of change, occuring at three major levels - agency, professional and front line staff. Regarding outcomes, Pilling (1992) commented that outcome measures in a number of studies has suggested that case management made little difference, while others showed a marked contrast to conventional care - a situation which the reviewers felt could be ascribed to different user groups.

Few methodological critiques appeared in the reviews analyzed, though Pilling (1992) noted that there existed no comparative studies of different types of case management and there were few attempts at the classic experiment (though the PSSRU, Age Concern and Resource Worker projects were, interestingly, cited as such). However, Phillips and Penhale (1996) included in their thoughtful survey a research agenda for evaluating case management into the next century. Four areas thought needful of research were identified: the client - especially the question of whether case management is sustaining vulnerable people with complex needs in

their home environment; the practice - especially ownership of the system in terms of which professional(s) can best work within its value system; the organization - especially establishing where case management is more successful as an administrative system or a client-focused system; and quality issues. A recommendation for longitudinal studies was also made in order to answer some of these questions. The research addressed will now be reviewed by type, as illustrated in tables 1.5 to 1.10.

1.5.3 Government monitoring

Two examples of Department of Health reviews of assessment and case management have been included here (table 1.5) as an illustration of the "official" type of literature alluded to in section 1.3.1. (fig. 1.2). The comment made by Challis et al (1998) that these studies lacked validity and reliability may be technically accurate, but arguably inappropriate, since they nowhere claimed to be scientific research. The first of these (SSI, 1993), published close to the official community care implementation date, very much conveys an impression of the urgency with which it was felt feedback and guidance needed to be produced in a relatively uncharted area of care. Very little detail of, or rationale for, the evaluation method was provided and limited bibliography or background details were evident. Nevertheless, some indication of process issues, both good and problematical, emerged from the seven projects reviewed. These included the commitment and enthusiasm of staff, balanced by concerns over eligibility criteria, the move to a needs-led culture, care planning, monitoring and training.

The 1994 monitoring paper was one of 14 thematic studies. The monitoring method, which favoured a variety of data collection sources, was noticeably more sophisticated than the previous year's exercise, though terms used were, predictably, in line with the White Paper (DoH, 1989a) and guidance documents (SSI 1991a, 1991b). By this time, some of the issues which were to become recurrent themes in the case management literature were beginning to emerge, and perhaps illustrate the effects of the rather unclear official

Table 1.5 Case management projects - government monitoring

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Older people and people with disability in Barking, Dagenham Croydon, Coventry, Sheffield, Lancashire, Oxfordshire.	April - Sept 1993	SSI 1993	DoH	Conducted by SSI inspectors with user and carer assessors. Based on 7 stages of assessment and case management in SSI guidance. In each SSD a sample of 6 referrals chosen. Interviews with users and staff plus inspection of records. Largely process measures.	Case manager designation: Mainly social workers, some OTs and some unqualified staff. Some joint visits with health professionals Model(s)/features: As defined by DoH, based on core stages Outcomes: Not specifically measured, though some involvement of users & carers and choice noted.
All main user groups including elderly, physical disability, learning disability and mental health in Berkshire, Cheshire, Hampshire, Hillingdon, St Helens, Suffolk, Westminster.	Jan - Feb 1994	DoH 1994c	DoH	Random selection of SSDs with associated HAs, trusts and independent providers. Review of documentation, semi-structured interviews with stakeholders (SSD and health managers, practitioners and independent agencies, and some users/carers) by teams of 6 from project group. Process and outcome measures based on core tasks of case management.	Case manager designation: Mainly social workers. Health personnel only assumed case management tasks in long established multidisciplinary teams and hospital settings. Model(s)/features: Varied, including "intensive", universal and brokerage models and use of support staff. Outcomes: Case management enbled more people with complex needs to remain by choice in community.

guidance noted above. For example, while the report commented on the variability of case management models across the seven projects under study, which might be expected in the light of non-prescriptive guidance, it also criticized the failure to sufficiently differentiate between intensive models, targeted at the minority of clients with complex needs, and the less intensive models, for the majority of lower need level clients. It also called for a clearer separation of the assessment and care planning processes to avoid the danger of undermining the very rationale of case management. Other observations also to appear in subsequent literature included budgetary devolution to team (rather than individual case manager) level, the complexity of assessment forms and the lack of integration between the micro- and macro-levels of contracting.

But perhaps the main area of concern was that of interagency working. It is notable from both of the Government evaluations that the majority of case managers had a social service background, and the picture to materialize from the 1994 report is one of health personnel being considerably disadvantaged by the emerging organizational frameworks. Certainly health staff based in social service departments experienced difficulty negotiating resources and felt that they had little authority in the coordinating role, instead being overburdened in their provider roles. That said, examples of good collaboration were apparent; one project had a nurse adviser to a social service team in an attempt to improve coordination, while some schemes had developed interagency training for the case management role.

Most significantly, this study attempted to look at outcome measures, albeit in a fairly rudimentary way. Most authorities claimed that more vulnerable people were being sustained at home with a better quality of life and (according to practitioners) greater involvement of users and carers. However, the question of managing care for those with less complex needs remained unresolved.

1.5.4 The PSSRU studies

In comparison with Government monitoring, the work of the Personal Social Services Research Unit (PSSRU) represented an attempt to evaluate in considerable depth the practice of case management in the community (table 1.6) and became something of a gold standard for subsequent research in the UK. The basic approach was what the authors variously termed "experimental" (Challis and Davies, 1986, p.18) or "quasi-experimental" (Challis et al, 1995, p.51), but using comparison, rather than control groups (admitted to be neither ethical nor practical) drawn from similar areas and subject to standard care. The difficulty of sustaining their chosen method over research projects where the researchers exercised less control became apparent in the 28 care in the community projects, which were dependent on the DHSS' constraints. In particular, the requirement to employ a common set of (quantitative) instruments across all client groups was felt to be an error resulting in poorer measurement than might be expected, and prompted the comment that decisions on choice of instruments "are always a compromise between the ideal and the practical" (Knapp et al, 1992, p.58).

The observation was obviously applicable to other aspects of the research. Knapp et al (1992) commented on further problems in relation to the number of variables involved in the studies, drawing boundaries around evaluations and comparing and aggregating information across individuals and projects. However, the researchers' solutions to these challenges should, perhaps, be heeded by others researching in the field. Their aim was both to build up a picture of each project through case studies, with individual clients as the unit of analysis, using both quantitative and qualitative evidence, and also to contribute to the overall body of research through the use of statistical, rather than randomized controls "to make various groups of community care clients comparable through appropriate statistical analysis and standardization" (Knapp et al, 1992, p.61). Subsequent replication of these methods by other researchers suggests the method had a high degree of success.

Table 1.6 The PSSRU projects (1)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Community Care Scheme: Elderly people likely to need residential care in Kent	1977-early 1980s	Challis & Davies 1985, Challis & Davies 1986, Challis 1994b	Monument Fund to 1980 then DHSS/ Personal Social Services Research Unit (PSSRU)	"Experimental design" comparing one group (n=92) receiving case management and one group (n=116) receiving standard care. Before/after interviews with clients & carers plus use of measures (QL etc) and observation. Use of "production of welfare" theoretical model involving costing of care packages through use of multivariate statistical techniques	Case manager designation: Social workers (3) Model/features: Clinical/complete case management, based on core tasks. Caseload 25-30. Integrated (service linked) model. Largely administrative with some brokerage. Use of community helpers. Decentralized budget Outcomes: More in experimental group remained at home at higher cost to NHS but less to SSD. Less health deterioration in project group & carers fared better.
Social Care Scheme (SCS): Elderly as Kent Health & Social Care Scheme (HSCS): Very dependent elderly. Both in Gateshead	1980-early 1990s	Challis et al 1990 Challis 1994b	DoH & DoE, Gateshead SSD & DHA/ PSSRU	SCS: Quasi-experimental design as Kent, comparing social care processes and cost effectiveness of project clients with matched pairs. HSCS: As SCS with matched control group from SCS	Case manager designation SCS:Social workers (2) HSCS: Social worker (1) and nurse (1) Model/features: Clinical/complete case management based on core tasks. Single agency (SSD), service linked. Multidisciplinary involvement in HSCS. Use of helpers. Caseload 25-30. Outcomes SCS: As Kent. No significant difference in costs. HSCS: More in project group stayed at home. Costs less to SSD and no significant difference to NHS but shift in resource use.

Table 1.6 (cont) The PSSRU projects (2)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
28 Care in the Community demonstration projects for people leaving hospital: Learning disability: Bolton, Derby, Liverpool, Torbay, Calderdale, Islington, Maidstone, Warwick, Camden, Kidderminster, Somerset. Mental health: Brent, Greenwich, W. Berks, Bucks, Waltham Forest, W. Lancs, Chichester, Warrington. Physical & multiple disabilities: Cambridge, Glossop. Elderly: Coventry, Darlington, Winchester, Camberwell, Hillingdon, St. Helens, W. Cumbria	1984-88	Cambridge 1990 Knapp et al 1990 Knapp et al 1992	DHSS/ PSSRU	Case studies of each project. Use of qualitative data, descriptive material and quantitative evidence. Quasi-experimental design comparing client groups in different settings with before/after measures. Specific questions on case management analyzed according to 5 core tasks.	Case manager designations: Dominated by social service staff. Only 2 teams were recruited solely from health, 15 were mixed and 11 from social service. Models/features:Based on 5 core tasks (as per DoH), though no particular model was laid down and no single model emerged as superior to others. Outcomes: Initial hopes of DHSS "largely realized" though outcomes for users were not analyzed in terms of case management alone.

Table 1.6 (cont) The PSSRU projects (3)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Frail elderly in Darlington One of 28 care in the community projects	1985-88	Challis et al 1989 Challis et al 1991a Challis et al 1991b Challis 1994b Challis et al 1995	DoH, Rowntree Trust/ PSSRU, Durham SSD & Darlington HA	As Kent & Gateshead, quasi-experimental design but using non-equivalent control group of similar patients in long-stay wards. Use of measures (dependency, morale, depression, quality of care), interviews (case managers, carers, service providers), costing measures and documentation.	Case manager designation: Service managers (3 social work and nursing staff) in multidisciplinary setting Model/features: As Kent & Gateshead. Core functions with emphasis on coordination rather than case manager undertaking all tasks. Use of home care assistants. Decentralized budget. Caseload about 20. Outcomes: Improvements in project group in subjective wellbeing, though not behavioural indicators. Less carer distress in project group and more clients remained at home. Less costly to NHS, though more to SSD.

The PSSRU studies also illustrate the challenge of establishing appropriate aims for case management research. It was in view of the many variables involved that a focus on cost and cost-effectiveness alone was felt to be over-simplistic, and the need was rather to look at the relationship between the cost, characteristics and circumstances of individual projects. In the Kent project (Challis and Davies, 1985) the usual research question of "is this mode less costly?" was thus rephrased to ask "for whom is this mode of care the most effective response?" (p. 578), while for the care in the community projects (Knapp et al, 1992) the aim became the examination of the circumstances in which cost-effective community care can be provided to meet the needs of particular groups of clients. Further issues in case management research, previously established in the literature, were also found to be relevant to the PSSRU work. These comprised: models of case management, case manager designation, interagency working, core tasks, outcomes and the future of case management.

Though undoubtedly robust in design, and detailed in description, the PSSRU studies have not, as noted, been completely immune from criticism. In particular, the issue of wider generalization of case management implementation, based on the research, has been questioned. Indeed, Knapp et al (1992) themselves have picked up this point in their somewhat more self-critical style of presentation, governed partly, no doubt, by a lesser degree of project "ownership" than the other studies. Knapp et al (1992) have pointed to features of the care in the community projects - such as extra start-up problems, the "Hawthorne" effect of being experimental, charismatic individuals and a possible loss of momentum - which may make replication of these demonstration projects less than straightforward.

Other commentators have also noted limitations regarding generalizability of the PSSRU work. Dant et al (1989) argued that this may be ascribed to methodological weaknesses, which obscure causal differences between experimental and comparative groups. These included the use of matched samples (described as "tricky" - p. 19), the "Hawthorne" effect, and failure to fully account for what constituted "standard provision", when it appeared that the project

provision became standard locally over time. Phillips and Penhale (1996), too, questioned replicability on the grounds of the high profile nature of the projects, given extra resources and smaller caseloads. Other features making the projects less than "typical" included the way problematical clients were filtered out, a focus on frail elderly, so that the model was questionable for other groups and difficulty distinguishing what specifically is beneficial about case management, as its practice was defined by the researchers themselves.

This issue of definitions is an important one in case management research, and the criticism perhaps rather unfair. The huge variability in defining case management has already been noted, so it becomes very necessary for researchers to clarify their own interpretation of the term. However, it must be said of the Kent project, at least (Challis and Davies, 1986) that a tendency to use the term "community care" instead of "case management" for the experimental group fails to differentiate the two in terms of outcomes - much like Knapp et al - although the title of the report ("Case Management in Community Care") would suggest the focus is on case management itself.

These criticisms apart, the PSSRU studies have set a standard and tone for subsequent research in the UK. As the authors of the report of the care in the community projects have pointed out, "conclusions about the effectiveness of community service programmes may have to come about slowly and cumulatively, based on convergent findings from many individual, less-than-ideal outcome studies" (Knapp et al, 1992, p.52). A selection of these individual studies will be reviewed next.

1.5.5 Other single case management projects

Despite the undoubted reputation of the PSSRU work, other early case management research projects in the UK achieved a similarly high degree of sophistication (table 1.7). The detailed Case Manager Project based in Camden and Islington (Pilling, 1988, 1992) was, unusually for the UK, based on an independent advocacy model,

Table 1.7 Other single case management projects (1)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
The Case Manager Project for people with physical disabilities and carers in Camden and Islington	1986-1987	Pilling 1988 Pilling 1992	King's Fund/ City University	Postal questionnaire to clients (n=64). Compared with small matched sample. Also questionnaires to service providers and scrutiny of case records.	Case manager designation: Two social workers (1 F/T, 1 P/T) Model/features: Autonomous (detached) status. Primary function as broker/advocate plus coordinator and counsellor. Use of contracts. Caseload (project total) 142. No extra budget. Outcomes: Most contracts completed. Some failures due to unobtainable services. Higher proportion of project clients than control satisfied.
Care for Elderly People at Home (CEPH) project for frail elderly in Gloucester	1986-1989	Dant et al 1989 Pharoah 1989 Dant & Gearing 1990	Gloucester HA & Nuffield Provincial Hospitals/ Open University & Policy Studies Institute	Descriptive, under 10 tasks of case management. Interviews with elderly clients (n=96) and carers (n=19). Analysis of care-coordinators' diaries.	Case manager designation: Care-coordinators (3) with academic, teaching and nursing qualifications. Model/features: Located in single agency (primary health care team). Caseload av. 32. Emphasis on keyworking and coordinating in addition to professional role. Work included counselling and advocacy. No direct control of resources for buying care. Outcomes: Not specifically measured, though evidence of better help under scheme.

Table 1.7 (cont) Other single case management projects (2)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Andover case management project for people with learning disability	1989-mainstream	Archer & Robertson 1990	Winchester HA & Hampshire SSD with MENCAP	Description of first year of project's operation	Case manager designation: Two case managers- 1 F/T, 1 P/T, 1 seconded by HA, 1 by SSD. 1 social worker and 1 district nurse also acted as case manager for 1 of their existing clients. Model/features: Multi-agency. Core tasks with emphasis on assessment, but broker also employed. Use of support workers. Caseload 9-10. One case manager had access to budget. Outcomes: Based on contracts and achievement of putting case management into practice
EPIC (Elderly People in the Community) project in Stirling	1990-1992	Lieberman 1990 Hudson 1993 Bland 1994 Bland 1996	Forth Valley Health Board. Central Regional SWD/ Stirling University (research funded by Nuffield Foundation)	Quasi-experimental design with use of comparison group of elderly in 3 primary health care centres. 9 case studies of EPIC clients, with client and carer interviews.	Case manager designation: Health visitor, CPN OT and social worker in multidisciplinary team. Model/features: As Kent/ Gateshead but joint social/health. Caseload 15-30. Use of home carers. Budget for buying in care. Outcomes: More elderly with dementia maintained at home than comparison though many still entered residential care. Case managers highly valued by carers though objective measures showed little difference.

Table 1.7 (cont) Other single case management projects (3)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Scarcroft Project for older people in N. Yorkshire (2 integrated projects)	1990-1993	Meethan et al 1993 Meethan & Thompson 1993	N. Yorks SSD, York HA, York City Council Housing Dept. & Age Concern York/ Rowntree Foundation & Social Policy Research Unit (SPRU)	Descriptive approach including observation, record review & interviews (care planners, project coordinator, care manager and users/carers of Intensive Home Support Service (IHSS)	Case manager designation:Project 1 - Care planners (district nurses & social workers) undertaking part-time care management activities. Project 2 - 1 care manager full-time in IHSS Model/features: Multi-agency but developed through SSD. No decentralized budget but care manager in IHSS had more control than care planners. Caseload in IHSS 11-14. Additional use of key workers. Outcomes: Not specifically measured, though all users of IHSS expressed satisfaction. Some clients subsequently entered residential care and care managers were perceived as a vital resource.

funded neither by purchaser nor provider agencies. Two designated case managers (one full-time, one part-time) were supported by one (part-time) administrator, but received no extra budget. This, predictably, manifested the pros and cons of this particular model and Dant et al (1989), in their critique of the project, noted both the positive aspects of advocacy itself and the limits to service provision which it entails. Hunter (1988) also detected problems in projects, like Camden, where an independent person is superimposed on to existing services, and questioned whether case management tasks should rather fall within the domain of particular professional groups (such as community nurses). In other words, he felt that the grafting on of new arrangements may reflect a failure of existing services, rather than a necessary adjunct. Making a similar point, Challis (1994b) commented that accountability is less of an issue when case management is performed by existing services, as distinct from one established for the purpose.

These were also the arguments used by Dant et al (1989) in justifying the model of their own project for elderly people in Gloucester. These authors suggested that an alternative to the danger of proliferating the complexity of service provision by creating a new professional might be to alter the responsibility, attitudes and team orientation of existing professional workers to include taking on a keyworking role for some of their clients (in this case within a primary health care tream). Keyworking was seen as a specific model of case management, though, unfortunately, the authors did not describe clearly how the two differ within their conceptualization. However, they did see the role of case managers (or care-coordinators as the project termed them) as not the sole province of social workers, but rather one appropriate for home helps or district nurses as well, as reflected in the backgrounds of the three care-coordinators in the project. And, although the pure US brokerage system was criticized for not leading readily to coordinated care, due to fragmented funding, a certain degree of advocacy was implicit in the case management role, such as in negotiations with solicitors and housing departments. However, one drawback to the model noted by Challis (1994b) was that the care

coordinators had an organizationally unclear role within the agency, and needed to make full use of their relationship skills.

In contrast to both the above projects, with their respective independent and health service bases, the Andover project for people with learning disabilities (Archer and Robertson, 1990) was of a multi-agency (social services and health) nature, with both social workers and community nurses acting as case managers, headed by a project leader and project management group. Like the PSSRU projects, use was made of support workers and, interestingly, a separate brokerage system was employed, suggesting a pure administrative model of case management (though it must be noted that all except one case manager had other roles in the organization). However, the separation of case management and provision, emphasized in the early case management rhetoric, proved difficult to operationalize. Rather, the report authors (Archer and Robertson, 1990) commented on the usefulness of access to, and ability to allocate, resources residing in the case managers and, therefore, close to the client.

The EPIC (Elderly People In the Community) project in Stirling had similarly strong management structures, headed by a project leader and steering group (Lieberman, 1990). Based in Scotland, which had experienced community care changes similar to England, but where progress had been slower, the project was, like Andover, multidisciplinary in nature but otherwise based on the Kent and Gateshead model (Bland, 1994). The conflict of implementing an advocacy role while working from a budget-holding organizational base was, again, noted by the health visitor-case manager (Bland, 1994). Bland (1994) also supported Hunter's (1988) and Dant et al's (1989) argument about the dangers of case management being seen as yet another management layer superimposed on to the local care system.

Finally, the Scarcroft project in Yorkshire, another multi-agency scheme, was noteworthy for its use of two concurrent models of case management. The first was characterized by the appointment of "care planners" (social workers and district nurses), whose case

management activities were accommodated within their existing workload (Meethan et al, 1993). This was obviously a source of pressure on the professionals involved, as the report compilers commented on the time-consuming nature of case management tasks, as a result of which not all documentation was completed (Meethan et al, 1993). The second project, the Intensive Home Support Service (IHSS) employed one full-time case manager and also made considerable use of keyworkers - front line workers with the most contact with clients, such as health care assistants, nursing auxiliaries and voluntary workers - to help with monitoring service delivery. But while case management was seen as providing coordination and continuity, advocacy was seen as a separate role, performed by a third party, usually a family member (Meethan and Thompson, 1993). Unfortunately, in the implementation of these models, agreements at strategic level did not involve front line workers, resulting in difficulties when put into practice (Meethan et al, 1993).

A variety of models of case management was thus demonstrated in this small sample of projects, ranging over: independent (brokerage) and agency-based, uni- and multi-disciplinary, part- and full-time, inclusive of, and separate from, keyworking and provision, ranging across different professional and client groups, and displaying a variety of titles. Differences in research design used was also notable, and may have been partly a reflection of these other factors. They may be broadly categorized under the umbrella terms of "quasi-experimental" (Camden Case Manager Project, EPIC) and "descriptive" (Gloucester CEPH, Andover and Scarcroft projects).

The two publications on the Camden project (Pilling, 1988, 1992) - the later being a reproduction in book form of the earlier first report - described a multi-method approach, based on a postal questionnaire to project clients (142 sent, 64 analyzed) and a small matched sample (16) of disabled people having recent contact with a social worker or OT. The use of a contrast group - emphatically described as not a control - was apparently thought inappropriate by some of the steering group. Further, Pilling (1988, 1992) thought that, with hindsight, the questionnaire was probably too long, despite an encouraging return rate of 66%. The second quasi-experimental

study, overtly based on the PSSRU experience, was EPIC (Lieberman, 1990, Bland, 1994, 1996). This study also made use of a comparison group, and, additionally, compiled case studies of the project clients. Data collection methods were not described, though it appears they comprised interviews with clients, using the screening/referral form as a tool.

The other three studies used a more descriptive style, with a lesser focus on outcomes. Again, multiple methods were in evidence, namely, the combination of interviews (Gloucester and Scarcroft), with diary analysis (Gloucester) or case studies, based on observation and analysis of records (Scarcroft). The Scarcroft project, unusually, was not described in any of the reviews accessed, but was interesting for the way that there appeared to be no outside intervention from the research team (from SPRU). Finally, the Andover project (Archer and Robertson, 1990) was only a short, first year report, rather than a detailed account, containing no references and little methodological detail, so cannot be compared with the completed studies. However, it represented an honest account of the problems of implementing case management in practice for people with learning disabilities, much along the lines of the Wakefield projects described in the next section.

Outcomes were variably documented in these studies and gave rise to debate, once again, about what may be appropriate outcome measures of the case management process. Camden (Pilling, 1988, 1992) and Andover (Archer and Robertson, 1990) based outcomes on what may be considered as the objective measure of whether contracts were completed. However, even this was not straight forward; Andover was not an outcome-focused project and the 1990 report accounts for the first year of its existence only, when long term results were not available. In Camden, although findings suggested that most contracts were completed, with a higher proportion of project clients satisfied than the control group, there arose the problem of differentiating perspectives on the matter, and it was apparent that more case managers than clients thought contracts to be completed (Pilling, 1988, 1992). It was also suggested that, more important than the actual numbers of fulfilled

contracts, were the reasons for non-completion; in the case management group these were more often due to unavailable services, problems outside the scope of the social worker or OT, or, possibly, the small number of "difficult to please" clients. Even then, Pilling (1988, 1992) questioned whether differences were due to case management *per se*, or rather to the individuals who held the office. Beardshaw and Towell (1990), meanwhile, suggested in their review that early evaluations of Camden and other service brokerage models cast doubt on their ability to improve outcomes for individual clients and families.

Like the Andover project, case management in Gloucester was more concerned with processes than outcomes. Although Dant et al (1989) suggested that there was evidence of better help for case managed clients, they also pointed to the likelihood that providing coordinated packages of care in the community for those needing them would cost more in the future, as more people lived longer and enjoyed the benefits of appropriate support. This lack of outcomes was noted by Challis (1994b), who criticized the study for its lack of comparative data on outcomes or costs (a major focus of his own work), though he did concede to the benefits described by the project's authors. Challis' point does raise the question of whether his approach, based on hard, economic evidence, is appropriate for all types of projects - helpful though this may be to meta-analysis of research findings if conducted consistently.

The EPIC project, based as it was on the PSSRU design, provides more direct comparison with the findings of Challis and his team. But although more elderly people with dementia (the only group for which outcomes were documented) remained at home than in the comparison group (Bland, 1994), a large number still entered residential care, prompting the author to comment on the lack of evidence of significant change, and the need to involve more elderly people in care policy for any real changes to occur. In a later analysis, Bland (1996) also suggested a number of reasons for the differences in outcome between the EPIC and PSSRU projects. These included: more long stay care availability in Scotland; different behaviour of clinicians; a greater acceptance of institutional

care; the greater degree of user impairment in dementia sufferers; the degree of carer stress; and the later stages of referral to the project, when clients had become more frail.

Finally, the Scarcroft project represented another process, rather than outcome focused report (Meethan and Thompson, 1993). Although clients of the IHSS expressed satisfaction, there was a notable tendency, as with many older people, to "make do", making these findings equivocal. Further, a number of those within the scheme were eventually referred, as in the EPIC project, for residential care.

So what conclusions for the future can be drawn from these projects? Pilling (1988, 1992) commented, regarding the Camden project, that "to be effective, case management for people with disabilities needs to be part of mainstream service provision ... yet it also has to maintain a certain separation and identity" (Pilling, 1992, p.43). This supports much of the argument emerging form the PSSRU programme and discussed earlier. The Camden model did, in fact, develop into what became the CHOICE initiative in Barnet (Brandon 1990, Pilling 1992), a voluntary orgsanization controlled by disabled people and carers, where the user worked with a case manager/broker. A strong commitment to the idea that case management should be independent and separate from service provision in this "second wave" project meant the terminology was, in fact, changed to "worker" or "advocate". However, Challis (1994b), in commenting on the CHOICE development, pointed out that a significant number of its clients would have liked the service to have more authority and resources than this model allowed, though they did value the sympathetic response and speed of action.

Hunter's (1988) evaluation of case management in Camden led to an "agenda for discussion" based on six issues arising from the project. These concerned: the level(s) of case management (the individual and/or the management and resource level); the need for clarity of case management aims and outcomes; the skills required for case management practice; the need for coordination at higher levels of case management; the translation of time- and resource-limited

projects into mainstream provision; and the implications of not having a designated budget for case management. In other words, many questions and issues remained unresolved and therefore, awaited further research findings.

Much the same conclusions were reached by Dant et al (1989), whose experience with the Gloucester project prompted the comment that no ideal model of case management existed, since success depends upon the setting, demography, political and social structures operating. For these authors the question remaining for research was how best to coordinate care for individuals. In terms of ways forward, two alternatives were suggested which may resolve the cost escalation problems mentioned above. Either new posts could be created for the keyworkers, along the lines of Camden and Kent, with the risk of creating barriers and hindering collaboration; or existing workers in the community could be grouped together into multidisciplinary teams, each acting as keyworkers for some of the relatively few elderly people who need care coordination. It was felt that the necessary skills for this were already present in the different professional backgrounds of these workers.

But Dant et al (1989) also drew attention to the perennial problem of integrating demonstration projects, most of which to date were outside, or on the margins of, the existing system, into its ambit. However, like Camden, an answer to this was partly seen in the further developments from the project, and Pilling (1992) noted that the Gloucester project spawned four further initiatives in the Gloucester area in response to Caring for People (DoH, 1989a). The issue of wider implementation was also one addressed by the authors of the Andover report (Archer and Robertson, 1990). Their doubt that the criteria established for the project would be useful for wider implementation, when there would be fewer resources, led to the conclusion that case management was not an easy answer to community care problems. Nevertheless, they did recommend the project be continued and further projects initiated, but with time to resolve any organizational issues away from the project orientation.

Like the other projects, the EPIC and Scarcroft schemes both gave rise to issues and recommendations based on the experiences. Bland (1994) commented, once again, on the time limited nature of EPIC and on the general resistance in the UK to major change, which could make case management a mainstream reality. She also felt that it remains to be seen whether different lead professionals may result in different models of case management, and that the case manager designation should be broadened out beyond the generally accepted social worker status. But the difficulties in adequately defining case management practice should not be underestimated: "it is undertandable", she wrote, "if other professionals working in the area think that they are doing case management already themselves (as they frequently assert) since the home carer service is the only novelty they are able to observe" (Bland, 1994, p.123). Much work done by case managers is, in other words, invisible, a description which has not infrequently been applied also to nursing (as outlined in section 1.4).

1.5.6 Other multiple projects and programmes

In addition to the number of single projects, such as those outlined, there developed from the mid-1980s, schemes along the lines of the PSSRU work (though less extensively or comprehensively documented), inasmuch as they involved more than one case management initiative, and these will now be considered (table 1.8). Although they tended to feature loose networks of projects in disparate areas, held together by the researcher or commentator (for example the work of ACIOG, RDP and King's Fund), there exist some examples of localities (for example Kent and Wakefield) where case management, often manifested by different models, became relatively well established more systematically. These are somewhat akin to the "spin-off" projects developing, for example, from Camden (CHOICE) and Gloucester, however, the former have developed simultaneously rather than in an evolutionary way and will therefore be described within this section.

Research approaches in these multiple projects displayed a similar variety to that noted in the single projects discussed above. The

Table 1.8 Other multiple projects and programmes (1)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Home Support projects for highly dependent old people with dementia in Ipswich and Newham	1983-1986	Askham et al 1987 Askham& Thompson 1990	Gatsby Trust & Guy's Hospital Trustees/ Age Concern Institute of Gerontology (ACIOG) King's College London & Guy's/St Thomas' Hospitals	"Action" project with action samples (n=54 & 41) and control samples (n=26 & 45). Structured interviews with "reliable witnesses", carers, supporters, development officers. Use of measures (depression, dementia, skills), costing, review of records and case monitoring. Comparison of the 2 areas.	Case manager designation: Development officers (one for each project) with local authority & OT backgrounds. Model/features:Role as educators, coordinators & keyworkers (Newham only). Some direct care. Use of local helpers. Caseloads max 16-20. Budgetary guidelines. Outcomes: Cost-effective, but no indication that case management enabled clients to stay at home longer nor that cognitive/ emotional wellbeing & ADL ability increased.
Long term mentally ill in 5 HAs & one SSD (not named) in England	1989-1990 (3 became mainstream)	Lear et al 1991 Ryan et al 1991 Ford et al 1992 Ford et al 1993 Lear 1993 Thornicroft et al 1993 Repper at al 1994	DoH, RHAs, DHAs, SSDs & Research and Development for Psychiatry (RDP)	Research based on 4 sites. Ethnomethodology/qualitative techniques. Open-ended interviews (n=188) with case managers, team leaders, managers, CPNs & clients. Observation of meetings & use of field notes. Mainly process measures	Case manager designation: Case managers (47) in teams. Various backgrounds inc. CPN (main group), social work, OT & no professional qualification. Model/features: Various structures. Usually in existing MDT or SSD based. Interlinked engagement & assessment. Usually clinical case management & coordination. Caseloads 10-25. Outcomes: 11% (n=24) engaged clients no longer receiving case management after 2 years. Inc. cost to health services

Table 1.8 (cont) Other multiple projects and programmes (2)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
2 projects: (1) People with learning disabilities discharged from long term hospital (2) 32 former residents of long stay psychiatric hospital Both in Wakefield	(1) 1989-1992 (2) 1990-1993	(1)Richardson & Higgins, 1990 Richardson & Higgins 1991 (2) Higgins 1994	Pontefract HA, Wakefield HA, Wakefield SSD, local MENCAP/ Nuffield Institute & Joseph Rowntree Foundation	(1) Descriptive/analytical rather than evaluative. General monitoring & commentary (2) In-depth, semi-structured interviews with service users, case managers, managers & other personnel. Process rather than outcome focus.	Case manager designation: (1) 2 with social work backgrounds (2) One working with resettlement service (various professionals). Model/features: (1+ 2) Core functions with emphasis on assessment (biographical). Coordination, monitoring, advocacy, not service delivery. Access to budget (RHA, clients' dowries). Caseloads 3 (1) & 32 (2). Outcomes: (1) One patient discharged from hospital by 1991. (2) All 32 patients resettled by Feb 1993. "Normalization" achieved, though dependency debatable.

Table 1.8 (cont) Other multiple projects and programmes (3)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
MAIN (Mutual Aid Implementation Network) projects for all client groups in 11 English LA departments: Devon, Lewisham, Walsall, Waltham Forest, Suffolk, Hammersmith & Fulham, Birmingham, Wandsworth, Hampshire (Andover), Croydon, Humberside	1990-1991	Beardshaw 1991	SSI & local SSDs/King's Fund	Report of MAIN's member participants who met for 5 two-day sessions. Focus on process of implementation	Case manager designation: Not stated in most projects, though examples of nurses and social workers given. Models/features: Various, including multidisciplinary teams, brokers, use of helpers and budget holding. Outcomes: Not measured.

Table 1.8 (cont) Other multiple projects and programmes (4)

Case management client group(s) and setting(s)	Dates of study	Source	Funding/ supporting organization	Research method(s)	Summary findings
Kent mainstream projects: (1) Older people at risk of institutional care in Kent	Mainstream (not dated)	King 1990 Ritchie 1992	Kent SSD	Anecdotal accounts	Case manager designation: Home care managers (132) most from social work Model/features: Service & budget management focus. Caseload 35. Use of community carers and client allowances Outcomes: Claimed cost effectiveness & client satisfaction.
(2) People with severe mental health problems in Dartford & Gravesham	1991 on	Positive Publications 1993	Local SSD	Internal audit after one year - descriptive account	Case manager designation: 4 with various backgrounds inc. RMN Model/features: Included some practical work/counselling. Use of support workers & MIND. Caseload 20. Devolved budget Outcomes: Many benefits listed from first year + some weaknesses.
(3) Maidstone Community Care Project (one of 28 Care in the Community projects)	1985-mainstream	Hasler 1990 Gilbert 1991 Knapp et al 1992 Challis 1994b	DHSS/ PSSRU, joint health and SSD	As Kent & Darlington - quasi-experimental design based on case studies & comparison group. Monitoring including descriptive & qualitative material + quantitative evidence	Case manager designation: From residential, home help & social work Model/features: Based on Kent scheme. Use of contracts, home care workers, private/res. & rented housing sectors. Caseload 20. Devolved budget. Outcomes: Suggests that quality of life improved for experimental group.
(4) Bexley Community Care Scheme for frail elderly	1984 on	Chambers 1986 Twigg et al 1990	Bexley SSD and Bexley Assoc. of Carers of the Elderly (ACE)	Anecdotal accounts & evaluation by community care manager, including costing	Case manager designation: Community care managers (managing role). Informal carers often case managers Model/features: "Paid carers" assess & support inc. advocacy. Use of allowances Outcomes: 1 of 26 unable to remain in community. Cost effective to LA.

ACIOG team described theirs as an "action" project, with "action" and "control" samples in both localities and data collected through interviews, outcome measures, costing, record analysis and case monitoring. Askham et al (1987) commented that samples were not perfectly matched - a feature seen to be common to such endeavours - so it was difficult to compare outcomes. They also felt that a crude quantitative analysis of data was less appropriate than the more detailed small group and case studies which they later undertook, for example detailing the characteristics, rather than just the number, of those in the samples remaining at home at twelve months. The later, more comprehensive report of the project (Askham and Thompson, 1990) put forward the view that, with the benefit of experience, the authors felt that standardized instruments used to assess depression and dementia were probably not appropriate for the type of (very frail) respondents in the samples. However, details of interview schedules, measures and costing calculations were helpfully (for other researchers) included in the report's appendices.

The RDP programme, with a comprehensive brief to establish the feasibility of case management for the long-term mentally ill and evaluate cost, quality and effectiveness, adopted a more qualitative approach from the outset, involving multiple methods of data collection, though Ford et al (1993) commented that there existed few methodological precedents to guide them in this decision. The authors did not name their chosen sites, though Lear's (1993) report on Hastings for a popular nursing journal named all six areas. No explanation was given for the decisions to name or not, however confidentiality has conventionally been an accepted principle of good research, although this review found otherwise, the counter argument in favour of publicizing innovative practice in case studies being but one possible explanation for this.

The work of Repper et al (1994) comprising 46 interviews with case managers and clients with long-term mental health problems formed a substudy of the RDP programme. The original plan to interview two clients of each of 17 case managers had to be abandoned when it was found that a number of clients were too vulnerable and frail or otherwise unsuitable for inclusion, reducing the anticipated number

of 33 to just 13. This is, perhaps, a useful lesson for future researchers in the area, possibly explaining the conclusion of the ACIOG team concerning instrumentation, though it does leave open to question the reasons for the success of the PSSRU and other similar work, assuming respondents to be equally frail. Details of Repper et al's (1994) framework for analysis were comprehensively documented, as were the methods adopted for the complete report (Ford et al, 1993), though this appears, unfortunately, to be unusual in most of the reports located.

The process-orientated, descriptive focus of the Wakefield projects contrasted with the RDP programme documentation and provided relatively little detail of method, though the later mental health project, based on interviews (Higgins, 1994) was more comprehensive in this respect than the learning disability project (Richardson and Higgins, 1990, 1991). The latter was presented as a series of working papers, describing in rather optimistic terms the early days of the project. Though avowedly written so that others may learn, the reports contained no literature review or references, but the practical illustrations included of case managed clients and of the case managers' work (in a diary form) would be useful for the target audience anticipated. The view presented of case management as a cyclical, continuing process, with an element of reflection, is also in keeping with the current idea of the "reflective practitioner" (Schön, 1991).

If details of method were sparse for the Wakefield projects, this was even more the case for the MAIN programme (Beardshaw, 1991), though this was, no doubt, a function of the espoused purpose of the scheme, to produce good practice examples, which nowhere claimed to be robust research. Nevertheless, the approach is interesting, with the reports of the five, two-day meetings of MAIN member participants not unlike the focus group, currently popular as an acceptable method in research proper (Bergen et al, 1996).

Certainly Beardshaw's (1991) work could be claimed as more systematic than most of the largely anecdotal minor Kent projects, though, once again, no claim to research was made, the Maidstone

project excepted (which adopted the PSSRU design). The Dartford and Gravesham project (Positive Publications, 1993) did include details of a one-year audit in addition to process description, plus three case scenarios, but, once again, lack of references would make it difficult for interested readers (likely to be mental health practitioners) to follow up the subject. The Bexley scheme also attempted some fairly basic evaluation (Chambers, 1986), though Twigg et al (1990), in their account, noted it as being "described evangelistically" by the author-participants.

It is difficult to draw methodological conclusions from such disparate approaches to case management research as those illustrated. However, defining the research aim is obviously of major importance, and it would further seem that multiple method approaches guarantee greater comprehensiveness and flexibility, with qualitative measures of data collection being a major asset in under-researched areas. Methods specific to nursing research in this area will be discussed in the next section.

The question of outcomes, previously seen to be notoriously difficult to establish and attribute for case management, was addressed by Askham et al (1987) in explaining their findings that the project group in the ACIOG study did not remain at home for longer than the "controls", as might be expected. The authors suggested the reason for this to lie in the kind of care problems presenting in the former, for example double incontinence and physical illness, which would militate against domiciliary care. It should be said that one of the specific aims of the project was to identify the limits to community care, and the conclusion that some types of care cannot be sustained in the community does, therefore, contribute usefully to the knowledge base. However, they also concluded that there existed a group that would have been unlikely to have stayed at home without the service. Further, the scheme was found to be cost-effective, although cost was predicted to rise over time.

Outcomes for the other multiple projects were also equivocal, being largely process-focused. Thus Repper's (1994) conclusion pertained largely to the enabling value system adopted by the case managers

she studied, while Beardshaw (1991) reported no objective outcome measures in the MAIN network. In Wakefield, Richardson and Higgins (1991) admitted that, on the face of it, with only one hospital discharge by 1991, the learning disability project was not a success. But they also highlighted the problem that the contribution of case management to any outcome is only part of the equation and suggested case managers should not be judged in their achievement where they have only limited control. Higgins (1994) again made the point in the mental health project that processes were more important than outcomes, while the brief Kent reports provided anecdotal evidence of (largely successful) outcomes. Data on outcomes in Maidstone (Knapp et al, 1992) are difficult to disentangle from the wider effects of community care in general, as with all the care in the community pilot sites.

Looking beyond the research work, Askham and Thompson (1990) acknowledged the "end of project ethics" in their report. While the project was enabled to continue in Newham, a multidisciplinary team, including a CPN, provided some continuity in Ipswich, where an agreement of support was negotiated with the social services department. Similarly, three of the original RDP projects continued beyond the pilot phase (Lear, 1993) and in Wakefield there were plans to incorporate the learning disability project into mainstream provision by 1992. However, Ford et al (1993) emphasized the need to "sell" case management and to demonstrate its effectiveness. Askham and Thompson (1990) called for further studies to build on existing findings and Thornicroft et al (1993) recommended in particular the tracking of different case management models over time in order to evaluate their contribution to community care. The overall conclusions to be drawn from these multiple projects are still, therefore, somewhat mixed, although Beardshaw (1991) is probably right to suggest case managment to be no Holy Grail or panacea. Research into the topic is by no means exhausted and examples located from the mid- to late-1990s suggests a move away from comprehensive examination of projects towards analysis of specific case management issues. These include community nurses' views on case management (Brittian, 1992), use of case manager time (Wilson, 1993), case management in practice in comparison

with official guidance (Baldwin, 1995), the views of older people on case management (Robertson, 1995), a comparative study of case management implementation processes (Lewis and Glennerster, 1996) and client satisfaction with case management (Cullen et al, 1997). These largely echo the comments already made about variable standards and designs, and the problematical nature of case management practice, with some constructive guidelines provided for future consideration.

1.5.7 Summary

This section addresses the third aim of the review. Research into case management in the UK has been slow to take off. Previous reviews of the literature have identified a number of common "process" themes, though outcome measures have suggested both positive and "no difference" effects. Few methodological critiques appear in the reviews, though a number of areas for future research have been identified.

The research may be discussed under five headings representing the types of literature located:

• Government monitoring. Although not intended as scientific research, this "official" literature appeared to become more sophisticated over time and highlighted issues which later became recurrent themes in the more general literature, such as the variety of case management models, problems of interagency working, the separation (or not) of assessment and care planning, budgetary devolution, and integration between the micro and macro levels of contracting for case management. Outcome measures in these studies were found to be rudimentary.

• The PSSRU studies. The work of the Personal Social Service Research Unit represented an attempt to evaluate in considerable depth the practice of case management in the community and became something of a "gold standard" for subsequent research in the UK. A basic, quasi-experimental approach, using comparison groups and focusing on the relationship between cost, characteristics and

circumstances of individual projects were the hallmarks of the research method, with clinical, or enhanced case management the preferred model. Detailed (and often multiple) accounts of three major PSSRU-initiated projects, plus the 28 government-sponsored care in the community projects analyzed case manager designation, interagency working, the core tasks of case management, budgetary administration and outcome measures, the latter being a particularly complex area, with varying interpretations. A number of commentators have questioned the degree of generalizability of the PSSRU work.

• Other single case management projects. A sample of five other single case management projects displayed a variety of models, ranging over: independent (brokerage) and agency-based, uni- and multidisciplinary, part- and full-time, inclusive of, and separate from, keyworking and service provision, ranging across different professional groups and displaying a variety of titles. Differences in research design were also marked, but may be broadly categorized under the umbrella terms of quasi-experimental and descriptive. Issues discussed, as with the PSSRU work, included multidisciplinary working and coordination, the interpretation of core functions of case management, budgetary arrangements and outcomes. Once again, the problems of establishing appropriate outcome measures meant studies tended to be largely process focused.

• Other multiple projects and programmes. A variety of models and interpretations was also seen in a further sample of studies comprising multiple, rather than isolated, case management projects. Issues arising were found to be similar to those discussed under previous headings, though there appeared to be a growing demarcation between work intended to be seen first and foremost as research, and work primarily aimed at producing examples of "good practice" and practical guidance for future implementation.

1.6 Nursing case management literature and research

1.6.1 Introduction

It is, perhaps, not surprising that the body of case management literature, and particularly research, on or by nurses in the UK, remains relatively small. This may be attributed to a number of factors noted in the literature, such as the relative "newness" of the concept, the variety of definitions and practices it embodies, the embryonic and still-developing body of research in both case management and nursing, and the implicit conferment by the government of lead agency (and, therefore, case manager) status on social services. However, a number of important pilot studies exist which have a major focus on the nursing role, and these, together with some more descriptive literature, will be reviewed in this section.

No comprehensive reviews of nursing case management in the UK were located. However, Ross and Elliot (1994) have compiled a portfolio of innovations in primary health care nursing, which helpfully summarises a number of initiatives involving nurses in the case management role and related practices, such as joint assessment. The overall aim of the publication is to "disseminate examples of good practice and innovation in primary health care nursing" (p.5) rather than to provide detailed accounts or reviews, and the target readers (largely practitioners and managers) are pointed to original sources for further detail. In addition, at least two authors from an earlier date (Ovretveit 1992, Thomas 1992) have provided examples of projects involving nurses as case managers, though Thomas (1992) focused on the learning disability specialism only, and it is not clear whether the cases cited are actual or hypothetical.

Items selected for review fell into two groupings. Firstly, 12 descriptive/anecdotal accounts were included of nurses involved in case management, largely (though not entirely) culled from reports in the popular nursing press between 1990 and 1998. These included few, if any, details of associated research, and varying degrees of detail on other parameters identified as important to case management research, although an attempt has been made to describe them under

uniform headings to enable some comparison (table 1.9). Secondly, 6 research-based reports, published between 1989 and 1997 have been treated in a similar way (table 1.10).

1.6.2 Descriptive accounts of nursing case management

Although not generally research based, these short accounts are useful for the description they provide of how nurses may operate in a case management role and of some of the issues arising from this, so supporting or refuting the literature considered thus far. For example, the popularity of older people as the target client group (5 studies) supports the work undertaken by the PSSRU, although the inclusion of other groups such as those with mental health problems and the disabled echoes the characteristic diversity of case management practice previously noted. However, there was some "crossover" in these groups in some cases (clients falling into more than one group, for example Henderson, 1990). There were also examples of apparently vague or unspecified targeting criteria (Fry 1992, George 1992, George 1993b), with one project demonstrating very focused targeting (Stokes, 1998). Cahill (unpublished) has provided a very helpful and comprehensive breakdown of the client characteristics found to be most appropriate to nursing case management in her experience.

Nurses acting as case managers were most commonly district nurses (7), with some mention of CPNs (3), health visitors (3) and the less specific "community nurse" (1). Generally the nurses functioned in a multidisciplinary team, often located in a health centre or general practice (5 of those stating location), as opposed to a social service base (1) or hospital (1). This appears to be an interesting feature both of later projects and of those involving nurses, and contrasts with previous, more general projects reviewed. However, most nurses appeared to be functioning only part-time in the case management role, though often there was evidence of clerical support and, in some cases, extra funding. As with the other UK-based projects studied, a variety of titles (7) to designate the case manager role was in use.

Table 1.9 Descriptive accounts of nursing case management (1)

Location/dates	Source(s)	Details	Issues/evaluation
York - Psychiatric Monitoring System 1986 on.	Henderson 1990	Client group: Elderly confused and long-term mentally ill discharged from hospital 1193 monitored Case managers: Any health care professional who accepts responsibility for monitoring patients. Inc. CPNs Model/functions: Inclusive, rather than referral system. Assessment, coordinating care, activating cases, reviewing (3 months - 1 year).	Much time spent contacting those who have "slipped through the net". Problem of refusal to be included in the system by small number. Large number of patients living at home. Positive feedback from clinicians, GPs, patients, carers & res. homes.
Oxford - Elmore Community Support Team 1988 on.	Trotter 1992	Client group: Chronically/multiply disabled/ challenging behaviour Case managers: "Support workers" (3) inc. CPN Model/functions: Independent multidisciplinary team inc. coordinator and secretary. DoH grant to 1990 then SSD funding. Advocacy, brokerage/negotiating package, supervision, liaison (police, housing, probation).	Improved communication with other agencies, client-based community support. Designation (support worker) not felt to represent denial of nursing status but attempt to undertake multidisciplinary work without being identified with one profession - "de-roling but not de-skilling".
E. Dorset - Disability Action Scheme 1990 on	George 1993c	Client group: Younger disabled Case managers : "Assessors" - bank nurse, health adviser and district nurse plus OT. Team inc. computer operator + link visitors. Model/functions:Assessment, monitoring/problem solving, referral, direct help (inc. advice/advocacy).	Independent evaluation: positive impact upon client problems. Clients valued information & assistance, though some help too late. Some DNs not enthusiastic. Reduction in number of hospital admissions & length of stay. "An example of the care management practice the Government intended under its care in the community policies".
Airedale, N. Yorks - Craven Joint Assessment Project 1990-92	Fry 1992 George 1993b	Client group: Clients (no group specified) in Craven Case managers: "Keyworkers" inc. district nurse, social worker and GP Model/functions: Multidisciplinary project funded by Rowntree Foundation. Main function assessment	Spin-off from larger (Craven Community Care) project. DNs felt to be appropriate assessors. Evaluated by research team: Improved joint planning and liaison, with less duplication, though some liaison problems remain. Elderly want more home care. Pace of change & costing implications of concern. GPs "essential".

Table 1.9 Descriptive accounts of nursing case management (2)

Location/dates	Source(s)	Details	Issues/evaluation
E. Berks 1990-91 then mainstream	Squire 1993	Client group: Elderly Case managers: Health visitor (p/t) and social worker as case managers in one of 5 pilots. Some clerical support. Based in health centre. Model/functions: Assessment (biog. approach), arranging services, budget management, counselling.	High number of initial referrals. Hostility & suspicion at first from soc. services staff over accepting HV assessments. Time consuming. Need for supervision. Overall broadening & sharing of expertise with colleagues. Consumer survey showed clients to be positive but need for more flexible home care. Case management a "dead end career" for nurses & HVs without soc. work qualification. When mainstream, levels of care fell.
Hampshire (Portsmouth) 1991-92	Ross & Elliot (1994) Brunnen & Korczak 1993	Client group: Older people Case managers: District nurse as case manager in team (6) with soc. work manager & clerical assistant. Soc. services based. Model/functions: Targeting (Stirling scale), joint assessment, care planning, costing, purchasing, contracting & assessing for entry to res. care.	Large number of people enabled to remain at home. Gained understanding of other agency working and pooling information. Training provided. But difficulty in interagency working - cultural and structural differences between health & social services. Marked effects of change.
E. Sussex/S. Downs - Ringmer Care Management Pilot Project 1991-92	Ross & Elliot (undated) George 1992 Murphy & Rodrigues 1992 Laurent 1993	Client group: Elderly and physically disabled Case managers: Care managers inc. health visitor based in general practice Model/functions: Mainly commissioning, not providing. Referral criteria, assessment (joint, modular format), designing package, securing delivery, reviewing and managing (separate care management) budget.	Good interagency working, though some "heated debate" over overlap of agencies. Consumer evaluation positive.
Lyme Community Care Unit, Dorset undated	George 1992	Client group: Not stated Case managers: District nurse as care manager/clinical facilitator based in gen. practice Model/functions: Coordinating work of HVs, DNs, CPN, physios, OTs, speech therapists & dietician. Close work with social services. Funded by existing community services budget & development money.	Important to preserve professional independence & competence. Need for training & support. Professional support services purchased from outside. Monitoring by FHSA/RHA/RCN through user evaluation & feedback + monitoring impact on nursing services. "Community-based nurses are often in a good position to take on case or care management functions"

Table 1.9 Descriptive accounts of nursing case management (3)

Location/dates	Source(s)	Details	Issues/evaluation
Edinburgh - The Currie Project 1994 on	Lieberman 1996	Client group: All community care client groups Case managers: District nurse & health visitor (p/t) with social worker (f/t) based in medical centre Model/functions: One of 4 multidisciplinary pilots under SW dept. & Health Board. Holistic assessment, access to (soc. services care managment) budget for purchasing. Some care provision	Confusion over having purchaser + provider roles & ideological conflict in assessing ability to pay. Referrals high - need for prioritization. But useful sharing of info. Nurses felt satisfaction & consolidated soc. care skills, esp. budgeting & ability to work across prof. boundaries. Training provided. GPs satisfied. "With appropriate training... community nursing staff are well able to assess social need"
Black Country (Sandwell) 1994 on	Bradbury & Solomon 1997 Bradbury et al 1998 Bradbury, 1999	Client group:Patients needing hospital care Case managers: Community nurses (3) & 2 SWs Model/functions: Integrated nursing team in one of first Primary Care Act pilot sites developed on multiagency basis. Coordination of patient care through hospital to discharge, implementation of care plan, liaison with hosp. soc. workers.	Improved documentation & communication between health & soc. care and primary & secondary care. Involvement of patients in care delivery. Number of readmissions, length of stay and anxiety levels reduced. Crisis management prevented.
Rochdale 1995-96	Cahill (unpublished)	Client group:See next column Case managers: Care managers include district nurses and CPNs Model/functions: Interagency model with focus on assessment, agreeing care plans, reviewing with providers, evaluation with patients/carers and reporting unmet need	DNs responsible for clients with no carer, in danger of losing independence, terminal illness, with complex nursing needs or where abuse suspected. Also where skills most appropriate. Pressures of change, time & new activities (eg assessing income). But advantages in one coordinator, ability to arrange admission to homes, access to additional resource & involvement in contracting.
Glasgow 1997-98	Stokes 1998	Client group: Elderly patients attending A/E & at risk of hospital admission Case managers: District nurses (2) as "winter care managers" based in Western Infirmary Model/features: Case managers buy community nursing, soc. services & transport to prevent hosp. admission. Budget from government for winter emergencies	Development of tailor-made services for patients. Collaboration between nurses in acute & community settings. Enthusiastic reaction from colleagues, though some (esp. GPs) wary. Most patients happy to go home. "The experience community nurses brought to the posts was vital".

In terms of the functions of case management performed by nurses, all of these were covered to a greater or lesser degree within the literature selected. Assessment (7 projects) and the care-planning/coordinating/ liaising cycle (9 projects) were the most frequently mentioned, with some reference to monitoring/reviewing (4), direct care provision/advocacy (4), budget management/commissioning (5), brokerage (1) and targeting (2). This largely supports the findings of the examination of nursing values and skills at section 1.4.5, though the slightly greater emphasis on budgeting and purchasing responsiblity than on care delivery is surprising - perhaps a sign of the adaptability of nursing also noted above. It also fails to support the thesis of Hunter (1988), who felt the nursing allegiance to care provision would militate against the assumption by nurses of independent case management.

Outcomes in this type of literature are difficult to assess, given the largely anecdotal accounts of the initiatives. Conclusions, though often unsubstantiated, tended to support a positive impact on the numbers of clients remaining at home and the number of hospital readmissions. They also recorded generally positive evaluations from users and professionals, despite some suspicion from social service staff (Squire, 1993) and lack of enthusiasm from district nurses (George, 1993c). General practitioners, on the whole, appeared positive (Henderson 1990, Lieberman 1996), though some remained wary (Stokes, 1998).

A number of recurrent issues emerged from this literature, for example the time consuming nature of case management, the need for supervision and the high number of referrals to case managers, with the consequent need to prioritize. These points have all been noted before in the literature. Another issue, and one of the major benefits of case management from the service perspective, appears to have been the improved communication between health and social services, and between primary and secondary care. However, the numerous references to the structural and cultural differences between different service sectors (particularly health and social are) also echoes much of the debate noted earlier (section 1.4.6).

Overall, the literature supports the suitability of nurses in the role of assessment and case management, despite some drawbacks, such as the inability to advance career-wise without a social service qualification. Although the dangers of role confusion were apparent (especially where there existed lack of clarity over the purchaser/provider divide), most writers thought the skills brought by nurses were both valuable and appropriate. Thus while roles may be changed, skills were often felt to be enhanced rather than diluted as was the fear noted above - "de-roling, but not de-skilling" as one practitioner put it (Trotter, 1992).

1.6.3 Nursing research and case management reports

Given the limited amount of general literature on nurse-focused case management in the UK, it is no surprise to find an even greater lack of research-based reports on the subject. Indeed, according to Lamb (1992), this sitution is also apparent in North America, where case management has been embraced much more readily by nurses. Lamb (1992) ascribed this situation to both conceptual and methodological issues surrounding case management research by nurses, which she herself attempted to address in her own research.

It is worth noting these issues for their applicability to UK nursing research. Firstly, Lamb (1992) observed that, conceptually, there has been no clear agreement about the definition and activities of nurse case managers, with few models seeming to be linked to any theoretical foundation in nursing or related disciplines. Further, there have been few insights into the context of such nursing practices. This point supports the findings in both the literature on UK case management, which highlighted varying interpretations (sections 1.3 and 1.5) and the literature on nursing theory, which suggests a slowly evolving theory base which, while having potential, has largely failed thus far to explicitly link its values to other disciplinary features (section 1.4) - though an attempt to do this in relation to case management has been offered in table 1.3.

Secondly, Lamb (1992) has pointed to methodological issues militating against nurse case management research, which centre on

the three main areas of sample selection, research design and instrumentation. In selecting a sample of case management users, the researcher is faced with the problem that it generally targets the most high risk and vulnerable clients, where health outcomes (a common measure in research) are not likely to be good. This also makes the selection of comparison groups difficult, since targeting criteria will often automatically subject all clients of a similar degree of disability to the "treatment" (case management) in question. As far as research design is concerned, Lamb (1992) found that most nursing research (no doubt partly for the above reasons) tended to favour a rather weak, pre-experimental design. She also commented that instrumentation tended to be chosen for its measurement of nursing concepts, such as self-care or symptom management, which do not always make for a good fit with the processes and outcomes of case management. Lamb (1992) concluded that: "the development of a scientifically credible body of knowledge on nurse case management will be essential to assure the expansion of this role" (p.16). In order to do this, she recommended a diversity of designs, including - as in her own research - qualitative methods to highlight the processes of case management with particular models of practice and particular client groups. Indeed, this diversity appears to have been successfully demonstrated in the UK (non-nurse focused) case management projects described at 1.5.

The six nurse case management projects under present analysis (table 1.10) also display wide variation. Although the client groups (with an emphasis on the elderly and disabled) and case manager designations (with an emphasis on district nurses and CPNs) reflect previous tendencies in case management practice, the interpretation of functions are too broad to summarize meaningfully. They appear to represent the spectrum of models discussed in previous sections, from the "clinical" focus to the managerial/purchaser model with no clinical input. It is interesting to note, however, that three studies, in defining their interpretation of case management, referred to guidelines set down by policy and/or the PSSRU. Outcomes of case management practice also appear mixed, often with positive indicators being counterbalanced by other, negative ones, though there was amost uniform comment on interprofessional relationships

Table 1.10 Nursing research and case management reports (1)

Client group(s) and settings	Dates of study	Source	Funding/supporting organization	Research method(s)	Summary findings
Long term mentally ill Greenwich, SE London	Jan.1989-July 1990	Muijen et al, 1994	SE Thames Regional HA, SE Inst of Public Health, Sainsbury Centre for Mental Health, Maudsley Hosp. & Greenwich HA	Patients randomized to receive intensive aftercare or generic care, both by CPNs, 41 in each group. Assessed at baseline, 6, 12 & 18 months by independent psychologist on a number of rating scales, plus patient/carer satisfaction, cost/benefit analysis, number of hospital admissions and length of stay. Treated to statistical analysis. Some analysis of subgroups.	Case managers: 3 CPNs as Community Support Team (CST), expanding to 4 in 1990. Model/functions: Refs. from psychiatric services only. Clinical input, advocacy, social issues. Caseload 8-11, expanding to 20-25. No multidisciplinary input. Findings: CST undertook a wider range of tasks. No difference found on any of outcome measures.
The Blaydon Project - Elderly people within one GP practice in Blaydon area of Gateshead	May 1991-April 1992	Peck, 1992	Newcastle Univ. HMSU, NHSTD/SSI Joint Training Project till July 1991, Gateshead SSD, Gateshead HA, Community Health Unit, Chainbridge GP practice from April 1992. No additional resources.	Case study with researcher acting as "consultant". Description of creation and evaluation through notes of meetings, assessment team diary, interviews with assessment team, case managers, service manager, users & carers, reviews of client files & client statistics.	Case managers: One nurse (DN/CPN) and one soc. worker based in general practice. Model/functions: From policy guidance & Gateshead experience in PSSRU project. Multidisciplinary. Referral from any source. Admission criteria in operation. Caseload 10+ existing clients. No devolved budget. Findings: Variation in assessment between 3 agencies. Lack of clarity about case management aims. Concerns about cost, fieldworkers' lack of involvement in planning, training, pressure on time & delays. Professionals unclear whether project had improved package of care for clients. But progress in mutual professional understanding & GP satisfaction

Table 1.10 Nursing research and case management reports (2)

Client group(s) and settings	Dates of study	Source	Funding/supporting organization	Research method(s)	Summary findings
Elderly & physically disabled clients from 2 inner city general practices.	Oct 1992-Sept 1993	Ross & Tissier 1994 Ross & Elliot 1994 Ross & Tissier 1997	Wandsworth HA, Wandsworth Borough Council, Merton, Sutton & Wandsworth FHSA, St George's Hosp Dept of General Practice. Funding from DoH localities money	Multi-method case study design. Retrospective analysis of GP referral, review of case records, in depth interviews with professionals (8), users (16) & carers (4) exploring structure, process & outcome	Case managers: One soc. worker (SW) & one DN based in soc. services & general practice. Model/functions: Multiagency pilot based on policy guidance, not involved in care provision. Budget held at team manager level in each discipline. SW supernumerary, DN also had caseload & team leader role. Findings: 162 referrals over one year with 54 core assessments (SW 46, DN 7). DN & SW valued relationship & shared knowledge, but some problems in communication due to different organizational systems. Some resistance to DN assessment. DN/GP communication improved. All users/carers positive about assessment, less so about services.
Clients with phyical disability within 2 general practices in N'thumberland	1994 - 1996	Pearson (unpublished)	Newcastle univ	Exploration of aims, processes & issues through data on costs, referral patterns & interviews with key professional stakeholders (GPs, DN, manager, admin staff) and some client groups	Case managers: One SW & one DN based in general practice. Model/functions: Based on policy guidance. Budget devolved to practice level. Findings: Aim of project & time allocated to functions initially unclear. Health/soc. service integration good at formal & informal levels. Differences in implementation between the 2 sites. SW full-time, DN part-time with less supervision. Overall experience thought to be positive - ease of access, follow-up rapid.

Table 1.10 Nursing research and case management reports (3)

Client group(s) and settings	Dates of study	Source	Funding/supporting organization	Research method(s)	Summary findings
Patients on a rehabilitation floor in an elderly care hospital.	Not stated	Waterman et al 1996	Manchester univ.	Qualitative interviews with case managers (7) & participant observation	Case managers: 5 sisters, 2 physiotherapists in hospital setting. Model/features: As case management in community & similar to primary nursing. Involvement in admission/discharge, organization & coordination. Caseload 5-6 patients. Use of support workers. Findings: General enthusiasm for case management with some anxiety/confusion over new roles and change, speed of implementation, communication, staff shortages, educational needs. Little impact on doctors. Some feelings of loss of control.
Elderly people in the community in N. London.	Main-stream	Edwards 1997	Kings College London.	Semi-structured interviews with 5 clients receiving care management.	Case managers: "Community living contacts" (CLC). Various backgrounds but soc. workers in this study. Model/functions: Design care plans, implement and monitor package. Assessment by separate lead assessors, leading to needs statement. Budget at manager level. Findings: Quality of relationship with professionals important. General satisfaction with service though some limitation in choice. Some unmet need and low self-esteem found in clients and lack of continuity in services.

(mostly with social services), despite simultaneous attendant problems. Finally, research methods ranged from a classic experiment, with rating scales and other quantitative measures, to case studies (2), using a multi-method (mostly qualitative) approach. Interviews and analysis of documentation appear to have been the most highly favoured data collection methods.

In looking more closely at the individual studies in this section, Lamb's (1992) critique, outlined above, may helpfully provide parameters for discussion. The first of these studies (Muijen et al, 1994), which used a randomized controlled design at a time (1989-90) when such an approach still appeared ethically sound, may be said within this framework to be strong methodologically, but weaker conceptually. Although the classic "experiment" was adhered to, neither case management nor the alternative generic care were operationally defined at the outset; instead the tasks undertaken by both groups of practitioners were detailed retrospectively as findings, following analysis. This analysis did show a demonstrable difference between generic and case management processes, the former being mainly concerned with medication supervision and counselling, with the latter including a wider range of activities, including family support and enhancing client skills. However, results also indicated little difference in outcomes between the two groups and Muijen et al (1994) provided a useful discussion of the possible reasons for this. These included inadequacies of the rating scales, poorly-focused care, the transfer of patients in the generic group to other support services, a comparative lack of training for the case managers and low input from other professions. The authors concluded that for case management to make an impact, the commitment of a range of disciplines, with proper preparation, support and resources, is needed.

In contrast to the work of Muijen et al (1994), the Blaydon Project (Peck, 1992) demonstrated a strong conceptual grasp of case management (based on policy guidance and the experiences of the Gateshead PSSRU project), but was, perhaps, weaker methodologically. Although reference was made to the case study approach (introduction), this was not expanded upon other than in

the discussion of the role of the consultant (p.4) and the list of data collection methods (p.39). To be fair, it must be said that the author referred throughout to "evaluation", rather than research, describing the report as an "honest account" (introduction), rather than an academic exercise. A paucity of references, together with the informal writing style, peppered with colloquialisms and humour, means that it cannot be analyzed along the same criteria as the more robust studies (although the set of appendices, including interview schedules, would be useful for researchers planning a similar approach).

That said, some interesting findings emerged from the project along with a discussion of the applicability of these to a wider setting. For example, the nurse and social worker case managers working together built on a tradition of interagency collaboration in the area, though Peck (1992) questioned whether this could be replicated elsewhere. But even despite this collaboration the social worker apparently had reservations about the idea of a district nurse acting as a case manager, since there was a "tendency for social service staff to 'possess' 'Caring for People' " (p.20). Although both agencies were committed to a joint approach, "social service staff representatives appeared surprised at the prospect of certain practical implications of this 'jointness' " (p.20).

As well as the positive messages to be found in the project, Peck (1992) described the problems encountered in Blaydon as being typical of those faced by any new pilot project conceived as an "add-on" within the context of existing services. He also noted drawbacks to the policy guidance model of case management, where assessment is separated from the design and implementation of the care package. The district nurse as case manager was geographically isolated from the assessment team and received fewer referrals as a result of this. A further difficulty encountered by practitioners was in assessing for needs which resources could not meet. Other issues noted in the evaluation included lack of clarity in the criteria for identifying clients, the need for more training, the failure to clarify responsibility for reviews and the fate of clients on the scheme once

the project ended. Most of these points have been encountered before in the literature surveyed.

The multi-method case study of care (case) management at the interface of social work, general practice and district nursing (Ross and Tissier 1994, Ross and Elliott 1994, Ross and Tissier 1997) provides another much-needed example of research focused on nurse case management. Like the Blaydon project (Peck, 1992), its implied definition of case management (through its elaboration in the literature review and helpful glossary of terms) was based on policy guidance. However, while the case manager was, by definition, "not involved in any direct service provision" (Ross and Tissier, 1994, p.7), the social worker and district nurse who assumed the role in the project were elsewhere described as "service providers" (Ross and Tissier, 1997, p.157), thus somewhat weakening this conceptual clarity in the operationalization of the term. Further, it is not clear whether the targeting/screening criteria, defined in relation to the area's community care plan, were rigorously enforced, or whether all referrals were, as implied, subjected to one of three levels of assessment described.

Neither is it entirely clear whether the district nurse was to be seen as having full case management responsibilities under the accepted definition of the term. Certainly, the social worker and district nurse were not seen as having identical roles within the project (unlike the Blaydon experience), the former being full-time in that capacity and the latter also having team leader and caseload responsibilities in her conventional role. Further, despite references to both as "care managers" (for example Ross and Tissier, 1994, p.18) and taking "joint responsibility for assessment and care management" (Ross and Tissier, 1997, p.154), the district nurse was elsewhere described as the "key worker" (Ross and Tissier, 1994, p.16), who may become case manager for certain clients only. In addition, the social worker case manager was based in a social service office, while all district nurses were GP based.

These points notwithstanding, issues arising from this project have, by implication, much to contribute to the debate about the

introduction of case management and the suitability of community nurses for the role in particular. The lack of time (and resources) devoted to the setting up of the project, the tensions inherent in the health/social care divide and the "end-of-project ethics" are not unfamiliar themes in the case management literature. A key observation was the marked imbalance between the number of assessments conducted by the social worker (46) and the district nurse (7) (plus one joint assessment), although the reasons for this were not fully explored. However, it was also noted that "from the small numbers of core assessments conducted by the district nurse, it appears that the group of clients that fits particularly well with the district nurse being care manager are those with a terminal illness" (Ross and Tissier, 1994, p.40). This finding perhaps illustrates the appropriateness of the case study approach to the topic, enabling the kind of focus on "characteristics", rather than "numbers" that Askham and Thompson (1987) found so helpful, and the study of case management processes recommended by Lamb (1992).

The unpublished study by Pearson (undated, but project dates 1994-96) bears much resemblance to that of Ross and Tissier (1994, 1997), with one (full-time) social worker and one (part-time) district nurse acting as lead case managers based in two general practices and apparently following the policy guidance model of case management (though with no obvious difference between the two disciplines in the role in this instance). There was also an emphasis on the exploration of processes and issues through interviews with key stakeholders. However, this is not a detailed report, being written half-way through the project's two-year lifespan, so it is perhaps unfair to conduct any comparative analysis, though some of its discussion points and recommendations do bear reiterating. For example, as so often noted before, an initial lack of clarity in outlining the project's aims made for operationalization problems. Differing perspectives between the health and social care disciplines were made manifest in areas such as assessment, where the district nurse was criticized as having a limited scope compared to the social worker. Other recommendations included a greater knowledge on the part of case managers about financial arrangements, more supervision (the district nurse had less than the social worker) and resources and an

increased awareness by GPs of case management. Overall, a high degree of satisfaction with the pilot project was noted and Pearson concluded that "it appears that a district nurse Lead Care Manager can function as effectively as a social worker Lead Care Manager" (no page no. given).

The final two studies considered in this section are perhaps not so central to the review as the previous papers, one (Waterman et al, 1996) because its focus was not community care and the other (Edwards, 1997) because it did not feature nurses in the case management role. Nevertheless, they have been included for reasons described below and for the novel slant they offer on the central issue.

The study by Waterman et al (1996), part of a larger evaluation project, was based in a hospital specializing in elderly care and is of interest here because five nursing sisters with two physiotherapists were designated case managers on a rehabilitation floor. The authors argued that ideals of case management practised in the hospital were similar to those familiar to community care, although the literature cited, which drew heavily on North American sources, casts some doubts on this, emphasizing, as it does, related concepts such as critical pathways, which are less familiar to a UK audience. It is apparent that a clinical model of case management was adopted and an imaginative and revealing ethnographic approach, including participant observation and interviews with case managers, focused on structure and process issues and revealed a shift towards a clinical emphasis and away from administrative functions. Nurse case managers remarked on the large adjustment and "boundary negotiation" this entailed and the greater degree of responsibility for a smaller number of patients. It is not clear whether there were differences between the nurse and physiotherapist case manager roles or whether they were allocated patients based on differential criteria. Further, as Waterman et al (1996) acknowledged, the sample was too small to claim generalizable findings. Nevertheless, the early stages of introducing a very new concept and the uncertainties attendant upon the change process were clearly apparent and must raise

awareness of the implications of implementing new nursing practices, such as case management, in any setting.

The study by Edwards (1997) is of interest in the present context on a number of counts. It was conducted by a nurse (as a student research dissertation), it was one of the few examples of mainstream case management to be analyzed and to do this from a user perspective. The case managers of the clients in the study were all social workers, although the area also employed other professionals in the role and while there is no reason to suppose user perceptions and experiences would be different with nurse case managers, it is a pity that this angle could not have been explored.

Conceptually, the model of case management described is interesting, if not entirely clear. Case managers were known as "community living contacts" (CLCs) in the area, while assessment was carried out by lead assessors. These were apparently different individuals, although there seemed to be some overlap in functions, especially in drawing up care plans and packages. The picture is somewhat reminiscent of that depicted by Ross and Tissier (1994) in their study, where nurses took on the case management role for particular clients only.

The views of case management users were gleaned through semi-structured interviews, with a small (n=5) sample, though, again, the author made no claims to generalizability. The problem of obtaining respondents among a very frail target group able to articulate their views is one already noted with regard to the RDP programme (Repper et al, 1994), though one also worth overcoming in order to yield valuable information. Many of the findings related to case management as a care system, rather than the case manager as an individual, and the author concluded that the promises of this mode of care delivery had not been fulfilled for this group. In particular she suggested that a different model of case management, such as that based on keyworking, could put community nurses in a more prominent position *vis à vis* the role.

1.6.4 Summary

This section addresses the fourth aim of the review.

• Although the amount of case management literature on or by nurses in the UK is at present limited, the few documented pilot studies with such a focus provide valuable insights for the nursing profession.

• Most of this literature comprises short, descriptive accounts of nurses in the case management role, though a few research studies exist, despite the methodological challenges these pose. Methods used in the latter group vary enormously, but tend to favour the use of interviews and documentation Both types support conclusions from literature previously considered in this review.

• Target client groups for nurse case managers are most commonly the elderly but also include those with mental health problems, the disabled and those with terminal illness.

• Nurses designated case managers are most commonly district nurses, with some mention of CPNs and health visitors. They generally function within a multidisciplinary team and only part-time in the role, unlike social work colleagues.

• Case management models adopted by nurses often lack conceptual clarity. There is a general focus on assessment and care planning, with some care delivery, though this may be said to weaken the "separatist" model of policy guidance. However, there appears to be a growing emphasis on purchasing and budgeting responsibilities.

• Outcomes are difficult to assess, either due to the anecdotal nature of initiatives, or the process emphasis of the research. Conclusions tend to support a positive impact on clients and enthusiasm from staff.

• However, a number of issues and difficulties recur in the literature including:

- structural and cultural differences between health and social services, but at the same time a generally positive change in interprofessional relations at all levels.

- the need for adequate supervision in the role and for adequate resources.

- the time-consuming nature of case management, especially for those functioning part-time in the role.

• Conclusions tend to support the appropriateness and effectiveness of nurses in the case managment role under certain circumstances, for example focusing on particular client needs or adopting a certain model of case management. However, because studies are few and small, these findings remain tentative.

2. Research methods

2.1 Introduction

The current health service climate is firmly grounded in evidence-based health care (Thompson, 1998), and evaluative work on case management can be seen as very much in keeping with this trend. However, the experimental randomized controlled trial (RCT) is still regarded by many as the gold standard in the medical research which largely underpins this (Dawson and Heyman, 1997) and, while research and development within clinical nursing practice forms part of this wider focus (Roe, 1998a), the evaluation of community services provided by health professions other than medicine may not be suited to this approach. Dawson and Heyman (1997) discussed the limitations of the RCT as applied to a domiciliary physiotherapy service, which included the following observations:

• RCTs themselves can only be termed corroborative, not true in the absolute sense if adopting a Popperian position.

• Services involving multidisciplinary interventions are more difficult to evaluate than medically managed services.

• Where interventions are complex, variable, long term and social in nature, this weakens the interpretation of RCTs.

• There are issues concerning the generalizability of demonstration and small scale projects and the take-up of inconclusive findings of trials of complex interventions by purchasers.

Dawson and Heyman (1997) encountered further problems with ethics committees over multi-centre approval, and with GPs, unhappy about randomizing their patients to the control (non-intervention) group, since they were convinced that physiotherapy had a positive role in the community. The authors concluded that in the community context, the **process** of care is equally important as **outcomes**, and that methodological pluralism, which includes

respondent perceptions as outcomes in their own right, is required if research is to be relevant.

Although much of the early case management research was based on the experimental, or at least quasi-experimental, method (Challis and Davies 1986, Challis et al 1989, Challis et al 1990), this has tended to become more untenable over time, for the reasons enumerated above, in particular the growing evidence for the effectiveness of case management and the ethical problems of depriving the intervention for control groups. Applying Dawson and Heyman's (1997) principles to the current research, it may be suggested that useful evaluative findings may be obtained through a focus on process issues, based on professional and client/carer perceptions. Aims and objectives were devised bearing this in mind.

2.2 Aims and objectives

The aim of the present study was to fill some of the gaps noted in the research and attempt to identify the current and potential relevance and value of case management to community nursing and its clientele.

Objectives emerging from this broad aim, and linking directly with the conclusions at 1.2 - 1.6 were to identify:

i) The extent and nature of the current community nursing involvement in case management as a prelude to more in-depth analysis.

ii) Case management projects involving community nurses with respect to:

- client groups and their characteristics
- case manager status and characteristics
- models of case management adopted and the consequent care practices and processes
- educational preparation
- management structures
- practice conflicts and ways of addressing them.

iii) How these variables relate to client, carer and professional perceptions of community nurse case management.

iv) The "durability" of case management as a model for community nursing in the light of changing social and health policy.

v) Recommendations for future service configuration and practice development based on these findings.

2.3 Overall design of the study

It was felt the objectives could be best met through a three stage design, comprising firstly, a preliminary telephone survey, secondly, a more detailed questionnaire survey and, thirdly (following informal recontact by telephone) a number of in-depth case studies. A further, longitudinal questionnaire to respondents of both the second and third stages was subsequently added as a means to addressing the fourth objective.

Although the case study stage would be the main focus and specifically address the second, third and (partially) fifth objectives, a questionnaire survey stage was felt to be necessary to provide some idea of the extent of nursing involvement in case management (first objective) and, at the same time, provide a database from which to draw the case studies. However, sample selection for a questionnaire posed additional problems, both theoretical and practical. Sampling theory tends to hold the view that probability (random) sampling is more highly respected than non-probability methods (Polit & Hungler, 1999) since greater confidence can be placed in its representativeness. However, its use assumes a population whose elements can be individually identified (Burns & Grove, 1997). In this instance the very reason for conducting the survey was because the "population" (of case management projects) was unknown.

From the practical viewpoint, even non-probability (convenience) sampling presented difficulties, since it begged the question of whom to target with the questionnaire (in other words, who, within the

community nursing service structure, would be most reliably informed about current practices). This issue proved problematical for a number of reasons. Firstly, in keeping with changing job descriptions (Carlisle, 1992) and a tendency towards decentralisation in the organisation of community nursing (Sylvester, 1992) new role titles were emerging which did not always readily denote area of responsibility (as exemplified, for example, by contemporary news items in the nursing press). Secondly, with the concepts of accountability (UKCC, 1992a & 1992b) and clinical facilitation currently being emphasised, it could no longer be assumed that it was the managers (rather than the practitioners themselves) who were the best informed on matters of practice. And, finally, with such apparently unequal, and on the whole tardy, movement towards the full implementation of community care (Audit Commission, 1992), a "convenient" sample may well have been one characterizing little or no action. It was, therefore, decided to add a further initial stage to the research design in the form of a telephone survey.

2.4 The telephone survey

2.4.1 Rationale

The use of the telephone as an effective tool in health care and health research has increased over the past few decades as technology has improved and larger proportions of the population have access to a telephone (Barriball et al, 1996). Indeed, the telephone survey has achieved a respected status as a legitimate means of data collection, inasmuch as it is represented in what are considered to be classic texts on survey research in general (for example, Oppenheim, 1992). However, critical analysis is less abundant. Sudman & Bradburn (1982), in discussing its indications (mainly in the area of social survey research where names are often randomly selected from telephone books) suggested that, with few exceptions, no differences are observed in the answers given to the same questions asked by mail, telephone or face to face and that other criteria should therefore determine the method of choice. They also discussed the advantages of combining mail and telephone procedures, though the favoured method would appear to involve sending the respondent

material first, then interviewing by telephone (thus allowing time to seek out any necessary information).

There appears to be more evidence of the use of the telephone survey in nursing research outside the U.K. than within. Cassiani et al (1992) adopted the method in order to determine the extent of the knowledge of the general population pertaining to schools of nursing in Brazil. However, selection of respondents was by stratified sampling from the telephone book, rather than targeted at particular individuals. Further, although they documented a 22.57% non-response rate, the authors failed to report how many times each number was attempted. Overall they concluded that the method proved efficient and recommended the expansion of its use in nursing research. Holzemer (1992), in a paper discussing the use of case management as a way of linking primary health care to self-care in the USA, used the telephone survey method in order to elicit from directors of community services data on the ability of community agencies to meet requests for social/supportive services. Holzemer, unfortunately, did not comment on the utility of the technique, but the reporting of findings implies it had at least some success.

Overall, the review of literature on the telephone method by Barriball et al (1996) suggested that, in particular, its potential to identify key informants and improve response rates within a multiple frame/mixed mode design were of relevance to the present research. Its major disadvantage appeared to be the high non-response rate, though the literature suggested that this could be offset by establishing a set number of recalls within the research protocol.

2.4.2 Aims

The telephone survey covered community nursing services in all 189 English Health Authorities (except Special Authorities) listed in the 1991 Handbook of Community Nursing (the most up to date then available). (This was, it should be said, at a time predating the large scale assumption, by the provider arm of these bodies, of trust status, although the concurrent process of negotiating this by many participants at the time of the research was but one added change

factor in the general *mêlée* of instability which characterized the background against which it was set). The aims were:

i) To identify a named individual in each Health Authority informed on the current state of community care initiatives within the area.

ii) To further identify individuals willing to complete a questionnaire where there was evidence of well advanced initiatives involving nurses.

iii) To gain a preliminary overview of current community nursing practices in the light of the community care legislation.

iv) To evaluate the telephone survey as a method of accessing an informed sample for subsequent stages of the research.

The reasons taken for this approach constituted attempts to solve the practical problems enumerated above:

• Titles in the Handbook of Community Nursing are sufficiently standardised to enable the researcher to have some idea of the level of community nursing management that was being approached.

• If the original contact proved insufficiently well informed, a further name could be requested.

• A contact by telephone, once established, would elicit a quicker response than one by mail.

• An established contact and agreement to complete a questionnaire would, hopefully, result in a higher response rate, while instances of refusal, or little innovation, would save unnecessary expenditure on canvassing for unlikely or uninformative responses.

This pragmatic approach has theoretical implications which need to be explored *vis à vis* maintaining methodological rigour in the research design and these are explored in terms of sample selection and data collection strategy.

2.4.3 Defining the population and sample.

Kalton (1983) stated that one of the first steps in survey design is to define the population to be studied, because the results will depend on the definition adopted. This would appear on the surface to be fairly straight forward, but again gives rise to debate, both in general and with respect to the present research in particular, where, as indicated, the population was an unknown quantity.

Part of the problem, at least, is that the terminology used in research texts is at present far from uniform in terms of the basic definitions of such words as "population", which is variously described as the aggregate (or entire set) of "individuals", "elements", "cases" or "units" to which the results of the research apply (Polit and Hungler, 1999, Burns and Grove, 1997, Kalton, 1983). The issue is not merely one of semantics, since some of these terms - notably "case" and "unit" (of analysis) - take on very precise meanings in certain types of research. It also confuses the issue of what exactly is to be defined.

In order to overcome this, the terms put forward by Moser and Kalton (1971) were adopted in order to identify two different aspects of a population, which have implications for the methodology selected. Moser and Kalton's reasoning was that, in discussing a population or a subset of this (that is, a sample) the researcher is actually considering two issues, i) who, or what, to collect information *from* (the respondents) and ii) who, or what, to collect information *about* (the subject matter of the resulting data). These aspects are correspondingly termed the "sampling units" and the "units of enquiry". In practice it would seem to be the case that the two are often synonymous, and it is only considered of importance to separate the two in the present research because they were not.

The difference may perhaps be best illustrated with respect to the classic research case study, where the sample may be said to comprise individual "cases". Yin (1994), in his account of the design, however, also made use of the term "unit of analysis", and

the two concepts can be upheld as equivalent to those of Moser and Kalton. Where case study research consists of a narrowly defined, single, or unique, case approach (for example, focusing on an individual's experiences) this may present no problems, since the individual *from* whom and *about* whom the information is collected will often be the same. Where, on the other hand, there are multiple "cases" (or, in Moser and Kalton's terms "units of enquiry") *about* which information is sought - for example health care innovations in different settings - the "units of analysis" (or Moser and Kalton's "sampling units") *from* which/whom data are collected may be different - for example different individuals involved in those innovations. This point will be further reviewed in the discussion on case study method.

It has already been suggested that the population in the present research be seen as consisting of case management projects. This can now be more clearly redefined as the unit of enquiry for the third stage of the study. For the first (telephone survey) stage, which is the focus of the present discussion, the unit of enquiry, if approached in terms of the survey objectives (outlined above), as Moser and Kalton (1971) suggest, may be identified as twofold: i) a named individual within each English Health Authority, able to provide reliable information on community nursing case management initiatives and willing to complete a questionnaire, and ii) the case management related initiative itself, about which very brief details were sought (in order to filter for appropriateness to enter the questionnaire stage). The sampling unit, on the other hand, can be defined as a community-based nurse for whom a contact number exists in the Handbook of Community Nursing. This overcame the "catch 22" situation of being unable initially to identify a source of informed respondents which, had sample identification been approached as a unitary stage (presupposing some knowledge of the population), would have been difficult, if not impossible, to plan for. A breakdown of the individual stages is illustrated in fig 2.1, where it can be seen that the data pertaining to the unit of enquiry in stage one became the basis for the definition of the sampling unit for stage two (the questionnaire survey). It illustrates how the researchers

worked from the unknown and undefined, to the known and definable.

Fig. 2.1. Stages of the research and corresponding sample selection procedure.

Stage	Sampling units (data sources)	Units of enquiry (focus of study)
1. Telephone survey	Named CNs from all English Health Authorities picked from CN Handbook (189)	Informed individual nurses & related CM initiatives (establish existence)
2. Questionnaire survey	All informed individual nurses willing to complete questionnaire on related CM initiatives (105)	CM initiatives (outline description)
3. Case studies	Selected individual nurses representing advanced CM initiatives (13)	CM initiatives (detailed description and evaluation)

Key: CN = community nurse/nursing
CM = case management

2.4.4 Data collection strategy

It was agreed that the cost of telephoning would be supported by the department of nursing where the research was based. There was also agreement to fund the part-time use of a research assistant, already based in the department, to help with this initial phase of the project. This subsequently proved a very valuable and necessary support. Interviewer preparation and training (for both researcher and assistant) included the development of an interview protocol (guidelines), the use of an introductory telephone sequence, strategies for building and sustaining rapport and familiarity with the record sheet (Barriball et al, 1996).

The strategy consisted of approaching each English Health Authority via the highest nursing level of generic (district nursing/health visiting) community nursing management in the first instance (thus, for instance, titles such as Unit General Manager, not necessarily indicative of a nursing post, were avoided, though this title sometimes subsequently became a secondary referral). Information was sought regarding the current state of community nursing in response to the key terms "NHS & Community Care Act, 1990", "interagency working" and "case management". No definition of the latter was offered unless requested, since it was felt this might constrain responses in relation to a concept which was, as demonstrated in the literature review, ill-defined at the time. Further contacts within the Health Authority depended upon the outcome of this interchange. If a comprehensive overview could be provided, no further contact was made other than a request to complete a questionnaire if appropriate. Where, however, little information could be provided on behalf of those in the fields of mental health or care of people with learning disabilities, contacts were made with those specialist management teams. A maximum of four calls were generally made to each number before moving on to either a separate field within the Health Authority or outside. This obviously gave rise to inequalities in contact with, and information obtained from, the various Authorities.

Thus the sample selected could be said to result from a combination of accidental (convenience), purposive (judgmental) and even snowballing (networking) techniques - the latter since other names were often forthcoming as further contacts and/or as recipients of the questionnaire. The technique also embraced multiphase characteristics (Moser & Kalton, 1971) and, given the fact that *every* Health Authority in England was approached, one could even argue for the assertion that this stage consisted of a (survey or accessible) population rather than a sample. But, more important than applying terminology is, as Morse (1986) has suggested, the fact that the sample should be judged appropriate (to the research question) and adequate (sufficient and of acceptable quality) for the type of research undertaken. In real life research, Morse commented,

methodology rarely achieves the ideal and it is felt that, within the limitations discussed, this eclectic approach served its purpose.

Reliability was difficult to measure, since it was not possible to apply the conventional tests. Two interviewers piloted the method using the protocol, which was in the form of an evolving flow-chart and acted as an *aide-memoire*, covering a variety of possible replies from the respondent. This, and the careful documenting of responses on the record sheet, ensured some consistency in the handling of data. The main survey was conducted largely by the research assistant, who found, with experience, the protocol became something of a constraint. A more informal, conversational approach to the interview later allowed for clarification of meaning and purpose on both sides, while still covering the substance of the protocol. A sound, and shared, background knowledge on the part of both interviewers enabled informed judgements to be made relating to whether the initiatives described by respondents constituted significant innovatory practices within the context of community care.

Validity of the emerging data was similarly difficult to establish. One accepted way of approaching this in qualitative methods is by triangulation, or using "multiple sources of evidence" (Yin, 1994) to verify findings and a crude variant of this was utilised in the present research by comparing data with documented evidence gleaned from the literature review. This technique obviously has weaknesses so, despite a *prima facie* good match, the degree of validity was difficult to establish.

Data recording via the record sheet was completed by hand at the time of the call and designed by the researchers for this purpose. This was later transferred to a computer database for analysis, when specific issues arising in the conversation were, as far as possible, matched against preset criteria indicative of various features of, or akin to, case management.

2.4.5 Response rate and profile

Of the 189 Health Authorities approached, contact was made with "informed" individuals in 161 (table 2.1), though this was rarely at the first attempt and often not via the first line of management

Table 2.1 Analysis of telephone survey sample

No. of Health Authorities:			No. of individuals sent questionnaires	No. of questionnaires sent
Approached	Contacted	Sent questionnaires		
189	161	98	105	122

approached. The non-response rate of 28 (14.8%) - that is, Health Authorities where there was failure to access individuals in either of the three lines of management after the maximum attempts - was therefore lower than that recorded by Cassiani et al (1992), though, as noted, these authors failed to mention the number of attempts they made. Of these 28, five were the result of "secondary" calls, where the primary respondent had diverted the interviewer to another named individual who, it was suggested, might fulfil the criteria requested.

In terms of the designation, or job titles, of informed respondents, this information was only requested from those agreeing to complete a questionnaire. In total, questionnaires were despatched to 100 designated and five non-designated individuals in 98 Health Authorities. This discrepancy arose due to the fact that in five cases the title of the respondent was not established and in five Health Authorities two or more designated individuals requested separate questionnaires. The 100 designated individual recipients carried 44 different titles between them (table 2.2) among which those incorporating the terms "manager" and "director" were the most popular.

The questionnaires sent to the 98 agreeing Health Authorities were for distribution to 122 individuals, either through the multiple request system (see above) or through the "channelling" of multiple copies through one respondent. Decisions on whether the

respondent's description of any project in the telephone survey fulfilled the criteria for inclusion into the questionnaire round was, to some extent, based on subjective judgement on the minimal amount of data it is possible to elicit in a short conversation.

Table 2.2. Individuals receiving questionnaires (i.e. with knowledge of case management projects)

i) By designation

Title	No. of individuals	No. of different titles
title inc. manager	53	22
title inc. director	22	9
title inc. adviser	8	6
nursing officer	5	1
senior nurse	5	1
other	7	5
not known	5	
Total	105	44

ii) By area of responsibility

Specialty	No.
CPN	43
DN/HV	34
CPN	15
All 3	4
CPN/CNLD	4
DN/CPN	4
DN/CNLD	1
Total	105

Key:

CPN = community psychiatric nursing

DN/HV = district nursing/health visiting

CNLD = community nurse learning disability

The telephone survey data were, by their very nature (which involved often unanticipated conversation on the part of respondents, within a restricted context) difficult to standardize. This was important in terms of facilitating analysis and enabling a "screening" procedure of the kind advocated by Yin (1993) prior to case selection for the final stage of the research. Therefore an intermediate questionnaire survey was undertaken, whose semi-structured format was based on findings from work already completed and reviewed in the literature.

2.5 The questionnaire survey

2.5.1 Rationale

The questionnaire is both very popular and useful in social survey research, with its advantages and limitations well rehearsed (Moser and Kalton 1971, Parahoo 1993, Mulhall 1998) and its principles identified (Moser and Kalton 1971, Oppenheim 1992, McColl 1993). It is perhaps important to note that this data collection method sits firmly within the quantitative paradigm (Parahoo 1993, Mulall 1998); even where open-ended questions are used, responses are taken at face value, with no opportunities to uncover underlying meanings or to interact with respondents, as in qualitative studies. Thus the detailed examination of case management processes and case manager/client perceptions were thought best suited to a case study approach. Nevertheless, a written questionnaire could cope more comprehensively, and with a greater degree of uniformity than the telephone survey responses already elicited, such that further, and more time-consuming, investigation could be limited to those sites where there was reasonable evidence for case management activity.

Perhaps the most serious limitation of the questionnaire method for current purposes was considered to be the potential for a poor response. Moser and Kalton (1971) quoted a rate of 30% - 40% to be not uncommon, although as little as 10%, and as much as 90% has been recorded. The authors warned that a rate of under 30% was likely to be of little value in terms of the sampling issues discussed above. Other drawbacks were thought to be of less relevance. For

example, the inability to provide for contextual or elaborative detail (Parahoo, 1993, Mulhall, 1998) could be compensated for in the case study phase; the lack of sponteneity (Moser and Kalton, 1971), problems of not knowing who actully formulates responses (Moser and Kalton 1971, Parahoo, 1993) and the ability to preview all the questions before answering (Moser and Kalton 1971, Mulhall 1998) may actually be considered as advantages in this instance, since accuracy of reporting was considered more important than immediacy of response or a particular information source. On the other hand the advantages of the questionnaire - uniformity, the avoidance of interviewer bias, relatively easy and fast analysis (Parahoo 1993, Mulhall, 1998) and economy of time and expenditure on the part of both the researcher and respondent (Moser and Kalton 1971, Mulhall, 1998) - were still felt to hold good for the research.

2.5.2 Questionnaire design

The questionnaire schedule (Appendix I), subsequently designed, sought answers pertaining to a number of issues raised in the literature, but not covered adequately in the telephone survey. These were largely of a descriptive nature, but included some evaluative material, namely:

- community nurse involvement in planning for case management
- numbers of community nurses acting as designated case managers
- status of nurses assuming this role
- model of case management being adopted, including details of budgetary control and other services involved
- client groups involved
- numbers on caseload
- perceptions of advantages and drawbacks of the initiative
- any evaluation of services completed or anticipated
- future plans or potential for development.

The combination of fixed choice and free response answers was designed to create a minimal "data set" from a respondent group

who, it was anticipated, would have limited time for questionnaire completion. At the same time, more detailed explanations were made welcome if there was time and inclination to provide this. One particular feature of the question order was that the title "case manager" occurred (along with alternative titles) only after a description of the community nursing initiative had been sought, in order not to sensitize the respondent to the subject under study, or, indeed, miss accounts of what amounted to case management, in essence, if not in name.

Advice was taken from colleagues in a nearby Nursing Research Unit who were experienced in questionnaire design and who suggested an appropriate layout for the the schedule in a booklet format. A covering letter, the tone of which is thought to be influential in encouraging a response (Moser and Kalton, 1971) was included in the mailing with a stamped, addressed return envelope. The letter outlined the purpose of the research, invited response, provided instructions for completion and assured confidentiality. In order to track non-respondents, and for ease of analysis, each questionnaire was assigned a code number, since there was no request for name of Health Authority or individual respondent.

2.5.3 Pilot study and main data collection strategy

Two rounds of pre-testing and pilot work were conducted. The first consisted of circulation of the questionnaire to a small number of professional colleagues (three) in community nursing management posts, inviting completion and, more importantly, comments on "user friendliness". A number of helpful suggestions were received, principally concerning conciseness and clarification of instructions, which were incorporated into a second draft, circulated to the same respondent-advisers. This was largely well received, with positive comments on the layout and instructions. The only real problem appeared to be how to handle responses when there was more than one project running. This was eventually dealt with through the rubric at the head of section B (see Appendix I), a subsidiary part of which was typed in italics.

The approved questionnaire was then sent out to a further pilot sample of seven recipients, drawn alphabetically from the list of positive telephone respondents. Five of these were returned and felt to be appropriately completed, suggesting that understanding of the instructions and rate of return were sufficiently satisfactory to be a basis for main study distribution. These five, but not the original three, were subsequently included in the main sample.

2.5.4 Response rate and data analysis

A total of 122 questionnaires was finally despatched to the named individuals previously contacted by telephone and 66 of these had been returned after one month. Reminders were sent to 42 of the non-respondents, representing different Health Authorities on which there were no data (and including the two non-respondents from the second pilot round). Of these, 17 were returned, giving an overall return rate of 83 (68%) from 74 (75.5%) Health Authorities, well above Moser and Kalton's (1971) "critical" level of 30%. This rate may have been influenced largely by the pre-questionnaire telephone call which sought, among other things, a willingness to respond to further requests for information. On the other hand, it has to be said that a few forms were poorly completed, demonstrating, perhaps, that even what might be considered comprehensive telephone briefing may fail to ensure complete understanding by respondents of the nature and aims of any given research, particularly where the research itself involves an element of concept clarification.

Analysis of returns proceeded by transferring data on to a database within an integrated package (Microsoft Works) and using its facilities to calculate totals occurring within individual response categories, i.e.: client group, nurse details (specialty, grade, number involved), nurse functions, other services involved, title used, time limit and funding of project, and plans for evaluation and/or extension. These data were treated to descriptive statistics. More qualitative material was analyzed manually around the major themes of the questionnaire itself. This provided material to inform the final stage of the design.

2.6 The case studies

2.6.1 Introduction

The case study is at once a familiar, yet elusive approach to research. It is familiar because it has been promoted by researchers and writers from a number of disciplines, for example education (Ball 1983, Burgess 1985, Hammersley 1986, Stake 1995), experimental psychology (Barlow and Hersen 1984, Robson 1993, Yin 1994) and nursing (Hutchinson 1990, Woods 1998, Ross and Tissier 1994). It is elusive, at least in nursing, because the case study method is usually only given minimal attention in general research textbooks (for example Burns and Grove 1997, Polit and Hungler 1999) and because much research appearing in academic nursing journals which claims to use the design fails to either define the author's interpretation, or offer a rationale (Woods, 1997). Such papers often include the label "case study" in the title, then proceed to infer that this equates with a qualitative - often phenomenological - approach, where the focus is a sample of one, or at least a very limited number (for example Titchen and Binnie 1993, Wilson 1993, Dale 1995).

The work of Stake (1994, 1995), who has written extensively on the case study method, would appear to support this observation beyond the field of nursing. His comment that "labels contribute little understanding of what researchers do" (1994, p 236) implies the need to describe and justify a chosen research method, rather than assume an accepted meaning. This is particularly true when the method in question - unlike, perhaps, the questionnaire and telephone surveys already described - has different interpretations. Thus:

> "custom is not so strong that researchers (other than graduate students) will get into trouble by calling anything they please a case study" (Stake, 1994, p.237)

For this reason, it is worth outlining the background, definition and issues pertaining to the method as adopted for the current research before discussing the chosen strategy in more detail.

2.6.2 Background

Hamel et al (1993), writing from the ethnographic sociological tradition, described the history of the case study in terms of a repeating rise-and-fall pattern, and detected three main sources of influence on its development. They credited the origin of the method to Malinowski, a Polish born Austrian, who took refuge in Melanesia during World War I. During this time, Malinowski engaged in the study of culture and anthropology through observation. His aim was to understand the meanings assigned to behaviour, and his "case" for study was the village or tribe.

A second seminal factor in case study development was seen by Hamel et al (1993) to be the French sociologists of the 19th century, in particular Le Play, who studied the cycles of decline and prosperity of societies through their component parts, families, which constituted the cases in this instance. However, his work was subsequently challenged as being too biased and narrow.

The third source of influence, also mentioned by Hammersley (1989), in his discussion of the method, was said to be the Chicago School of Sociology, which, at the end of the 19th century, developed the first important form of qualitative research in that discipline. In this context, the "case" of the method was a small, local community. However, Hamel et al (1993) described how the statistical survey method subsequently gained ground as the main approach to research in sociology, and the case study was temporarily discredited, only to revive some time later under the "new ethnography". It was during this later flourishing that the classic study by Whyte (1955) of Street Corner Society - quoted in most of the texts on the subject - was written.

But this rather narrow interpretation of case study research, based firmly in the ethnographic tradition, has been challenged by researchers from the scientific field. Barlow and Hersen (1984), for example, who were experimental psychologists, saw the growth of clinical replication studies in their own field as influential to case study development. They interpreted the significant work of

psychologists, such as Freud, in the 19th and early 20th centuries, who developed theories based on the treatment of individuals, as being equivalent to the single case experiment. This method was said to have been the basis for most experimental studies before clinicians became aware of the principles of control, manipulation and randomization. Again, though, Barlow and Hersen have commented on the exaggerated claims to success which led to the "case study" falling, once again, into disrepute.

Further, and apart from the major research paradigms, Hammersley (1989) has detected the influence of various professional practices on the case study. These included the case work of social workers, case reports of journalists and case examples in nursing and teaching. This diversity of influences was offered by Hammersley (1989) as an explanation for the variety (and often lack of clarity) in the conceptual interpretation of the method by its different proponents. While this explanation may be true, it should, perhaps, suggest caution when reading research to ensure that the author is actually describing a research method rather than a vehicle for detailed description of a single phenomenon, perhaps for other purposes.

2.6.3 Defining case study research

This point is of importance when searching for a definition of case study research. Hammersley (1989), in his account of the Chicago School, has illustrated the point in putting forward their view:

> "In essence, the term "case study" referred to the collection of detailed, relatively unstructured information from a range of sources about a particular individual, group or institution, usually including the accounts of subjects themselves"
>
> (Hammersley, 1989, p.93)

Even the novice nurse research student can point out that "relatively unstructured information" sits uneasily with the traditional definition of research as a systematic process, involving discipline and structure (for example Macleod Clark and Hockey 1989, Powers and Knapp 1990), aimed at extending a given body of knowledge. This is not to

say that Hammersley himself supported the view of the Chicago School - indeed his earlier collection of case studies in classroom research (Hammersley, 1986), which included a variety of approaches, does not indicate any particular view. Nevertheless, his edited collection of school studies (1983) appears to support the placing of case study research firmly within the qualitative (and, more specifically, the ethnographic) paradigm (Ball, 1983).

This is a not uncommon position amongst researchers. In education, Lawrence Stenhouse (also an advocate of the ethnographic tradition) developed the idea of the "case record" as the ordered, but untheorized presentation of data, which formed the building block of the case study - "the product of fieldworkers' reflective engagement with an individual case record" (Ruddock, 1985, p.102). In nursing the case study has been categorized by Parse et al (1985) as an example of the descriptive method within the qualitative framework. Both saw the purpose of the method as the in-depth investigation of a particular unit or institution, a view subsequently accepted by other writers (for example Hutchinson 1990, Powers and Knapp 1990).

In contrast stands the definition put forward by Yin (1994), who saw the case study as:

> "An empirical enquiry that:
> • investigates a contemporary phenomenon within its real-life context; when
> • the boundaries between phenomenon and context are not clearly evident"

His definition was further elaborated in a second set of conditions:

> "The case study enquiry:
> • copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result
> • relies on multiple sources of evidence, with data converging in a triangulating fashion; and as another result
> • benefits from the prior development of theoretical

propositions to guide data collection and analysis"
Yin, 1994, p.13

This at once differentiates case study research, not only from experimental and quasi-experimental designs, which aim to divorce the phenomenon under study from its context, but also from historical research, which does not study contemporary events, and surveys, which attempt to limit the number of variables under investigation. Yin subsequently challenged many of the commonly held assumptions about case study research; it was not to be seen as synonymous with ethnography, nor did it always focus on one single person, group or institution. Finally, though in-depth in nature, data were certainly not to be seen as lacking structure.

However, though persuasive and comprehensively explored, Yin's concept of case study research does bear scrutiny, particularly in the context of any particular application. Four major areas of debate will, therefore, be considered in relation to the strategy adopted in the current research. These issues focus on i) case and context, ii) external validity, iii) triangulation and iv) the relationship to theory, and are roughly equivalent to the four major sections of Yin's definition.

2.6.4 Issues in case study research

i) Case and context

In stating that the boundaries between phenomenon and context are not clearly demarcated, Yin (1994) seemed clear that the case study would necessarily include data relating to that context because the researcher "deliberately wanted to cover contextual conditions" (p.13). This appears to have marked a development in Yin's thinking, since the first and revised editions of his basic text (1984, 1989) failed to mention this inclusiveness, while his later book of applications of case study method (1993) implied the point only through the addition to his definition for the first time of the clause about variables and data points (see above). At the same time, his emphasis on the need to

clearly define the case meant that case-related and context-related data were not to be treated in the same way.

This poses challenges for the researcher, not least because his examples in the "applications" book (Yin, 1993) fail to illustrate in detail how this principle should be operationalized. Nevertheless, Yin's unfolding theory is perhaps more helpful than that of Stake, who wrote, on the one hand, about the case as "a bounded system" (Stake, 1995, p.2) and "the boundaries of the case" (1994, p.237), while referring, on the other hand, to the "infinitely complex" nature of case and context, where "the phenomena are fluid and elusive" (1995, p.33). Contextual issues have been clearly shown to be important to the phenomenon of case management, in the form of national policy, professional theory and local organizational structures, so Yin's specific counsel of inclusion would certainly seem appropriate here.

Most researchers appear to support Yin's emphasis on the importance of a clear definition of "the case". However, experts differ as to whether this should be imposed by the researcher or be evolutionary in nature. Hamel et al (1993) wrote about the need to actively select the ideal case in order to grasp the object of study and of the need for the researcher to intervene to produce a definition rather than having it imposed by the field or key informants. Robson (1993), who, in many respects, comes closer to Yin in his conceptualization of the case study than most other writers, has referred to both "prestructured" and "emergent" designs, with a necessary trade-off between looseness and selectivity, meaning that most research falls somewhere between these two extremes. But Robson's "real world" research leaves room for a type of pragmatism which Yin would probably denounce as unsatisfactory. Although not overtly allied to one particular camp here, Yin implied researcher control over the case definition in his assertion that it should follow logically from the nature of the research question and focus on the possession of characteristics of interest. Moreover, in order that findings can be compared with previous research, "key definitions should not be idiosyncratic. Rather, each case study .... should be similar to those previously studied by others" (Yin, 1994, p.25). This approach would sit readily with the subject of case management, as it appears in the literature.

In seeking a definition, the question arises of whether anything (within, perhaps, the above limitations) can be a case if so designated. Stake (1995) strongly countered this position with the example of a teacher who, he suggested, could appropriately constitute a case, but not her teaching, since this would lack specificity. Interestingly, Yin (1994) disagreed with this assertion, claiming Stake himself to be too broad in his approach. Yin's wording, in a footnote to the subject of definitions, implies that Stake failed to differentiate the case study (a research method) and the case (its object). Defining the former in terms of an entity would mean that any object could then be labelled a case study regardless of methodology used. This would clearly belittle the discipline. The case, on the other hand, according to Yin (1994), "can be some event or entity that is less well defined than a single individual" (the usual choice and that adopted by Stake) and "case studies have been done about decisions, about programs, about the implementation process and about organizational change" (p.22). There is a substantial difference here, and this broader view was felt to hold potential for the present study, where case management practice, within a given location (case study site), rather than the practitioner, would provide the most useful focus. This was because the research question revolved around professional theory and practice from two disciplines (nursing and case management) and their interrelationship. Individual practitioners could be seen as the vehicles for this practice.

Discussion about defining "the case" prompts clarification of other terminology, in particular the term "unit of analysis", briefly discussed at 2.4.3 above. This latter term is one example of research terminology which is commonly used and accepted, but rarely defined. Yin appeared, initially, to imply equivalence with case in his reference to "the definition of the unit of analysis (**and therefore of the case**) ..." (Yin, 1994, p.22, my emphasis) and this may be further taken as read in his summary of the same section, where he referred to "the unit of analysis (**or the case itself**) ..." (p.44). However, in a later discussion on different types of case study designs, Yin described a 2x2 matrix, where the horizontal axis represented single and multiple case designs and the other what he termed "holistic" and "embedded" designs, since "within these two types [that is, single and multiple case

designs] there can also be unitary or multiple units of analysis" (Fig.2.2) (Yin, 1994, p.38). In other words, there is an implication that the case may be disaggregated for the purpose of analysis.

Fig 2.2 Basic types of design for case studies

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	Single case designs	Multiple case designs
Holistic (single unit of analysis)	TYPE 1	TYPE 3
Embedded (multiple units of analysis)	TYPE 2	TYPE 4

This is a point not addressed by the other main writers on case study research, though Stake's (1995) illustrative vignette of Harper School made reference to the "case within a case" as he studied classroom, teacher and pupil in order to build up the picture of the school itself. Stake is one of only a few researchers, like Yin, to detail the case study approach in action, and this is naturally useful for other researchers and adds credibility to their theory.

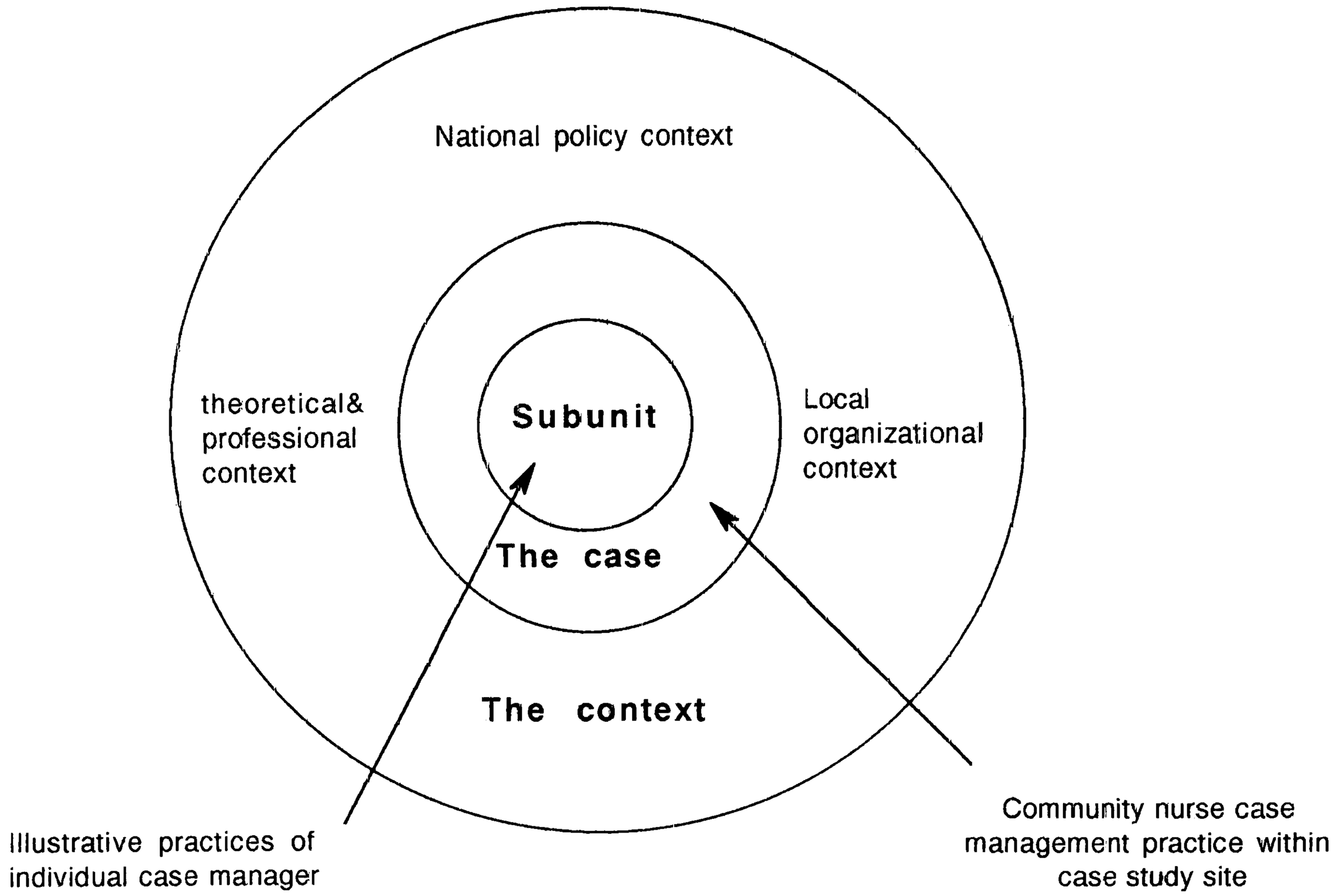
In the present research into case management, this issue was dealt with in two ways. Firstly, it was decided to adopt Yin's (and Stake's) notion of designating a unit smaller than the case for purposes of analysis, in order to build up the case picture. Thus the case (community nurse case management practice within the case study

site) was subdivided into its component parts (the practices of individual case managers). In order to be clear about terminology, the former (the case) was termed the main unit and the latter (individual practice) a subunit (fig 2.3). This overcomes Yin's rather confusing, and various references to "the unit", "embedded units" and, in one instance, "subunits" (p.41). However, unlike Yin and Stake in their implications (though the point was made explicit by neither) the unit and subunit were qualitatively the same, that is, comprised of case management practice, rather than, for example, individuals. It was thought this provided the sounder rationale for overall conclusions about the case.

Secondly, the application of Moser and Kalton's (1971) terminology, discussed above, which differentiated sampling units (the sources of data collection) and units of enquiry (the subjects or variables to be measured) was maintained. Thus, units of enquiry comprised the case as the main unit and individual case management practices as the subunits. Since data about the relevant contexts were also to be included, these were termed contextual units (of enquiry).

Determination of the sampling units depended on the chosen methods of data collection, and in this instance it seemed that interviews with case management project participants, together with the scrutiny of local documentation relating to case management policies, would best elicit the type of data required to expand on the questionnaire replies and fulfil the research aims. The interview was seen as a principle data collection method in case study research by Stake (1995). In addition, the literature on different individual case management projects would provide contextual data on types of local organizational structures and practices which impact upon case management. The literature on nursing values as they related to case management and on national policy documents already reviewed would supply further contextual data on professional disciplinary theory and national policy respectively. The three levels of contextual data would be likely to be mediated by individual notions of case management in its operationalization (Lipsky, 1980). Thus the data collection methods equated with each of the multiple sources of evidence used, while the individual sources of data within these methods equated to what Yin termed "data points". Although Yin

Fig. 2.3 The case and the context



failed to define this term, this interpretation is consistent with his usage. For national policy documentation this meant the White Paper (DoH, 1989a), statute and implementation guidance; for nursing literature this meant papers on nursing theories, concepts and principles; for local case management literature this meant individual case management research projects, and for interview data this meant the individual nurse-case managers, their line managers, patients and carers. A schema of this terminology used in the research design is depicted in fig. 2.4

Seventeen case study sites were identified from the questionnaire data for in-depth analysis. Sample selection depended on the following pre-set criteria:

• Each case fulfilled, in broad terms, the designated functions of case management as identified in the literature.

• A variety of professional specialisms and levels of practice and client groups were represented.

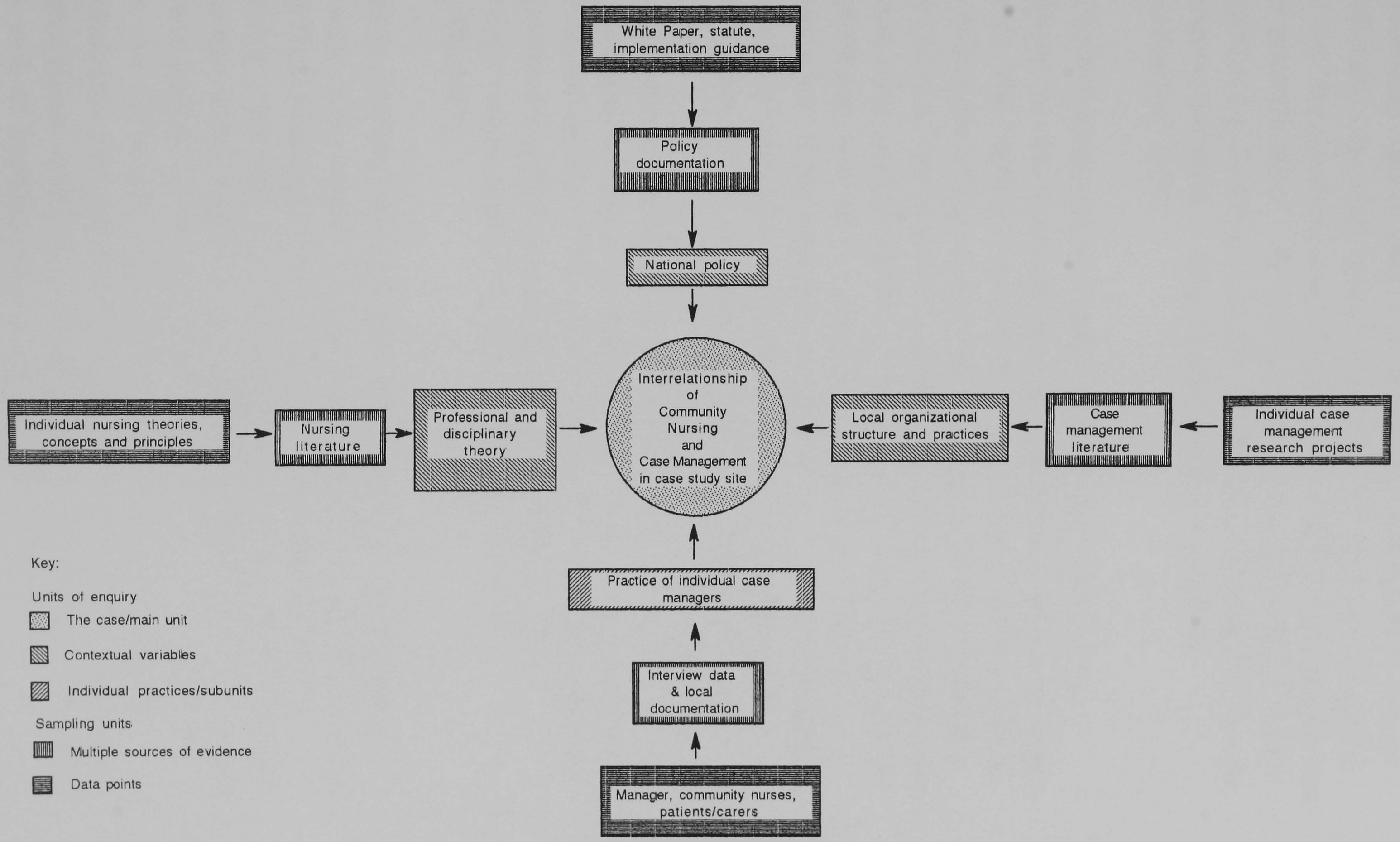
• Different geographical locations in England (covering N.E., N.W., W. Midlands, E. Anglia, S.W., Southern England and S.E.) were included, representing various health and social structures.

ii) External validity

An understanding of the nature of the sampling unit is crucial to an understanding of the nature of external validity within case study design. Critics have argued that case study research is a poor basis for generalization (Stake, 1995) but this criticism is based on traditional sampling theory, itself based on the representativeness of sample selection and the consequent ability to make inferences about a population. Since case selection is based largely on other factors, as noted above, the question arises of whether generalizability is a redundant concept in this context.

Most proponents would argue not, although the terminology may need to be changed. Stake (1995) suggested that the purpose of much

Fig 2.4 Variables, data points and multiple sources of evidence



research, not just case study approaches, is seldom an entirely new understanding of phenomena, but rather a "refinement of understanding" (p.7). This is particularly so with what he termed the collective case study design, where several cases are selected in order that "by counter-example [each] case study invites modification of the generalization" ...though "a positive example is likely neither to establish a generalization nor to modify one, but may increase the confidence that readers have in their (or the researcher's) generalization" (p.8).

Stake (1995) identified two further types of case study which developed his conceptualization of external validity as applied to this method. The "intrinsic" study is a "given" in the sense that there is little researcher influence over case selection, and the researcher is interested in it "not because by studying it we learn about other cases or about some general problem, but because we need to learn about that particular case" (p.3). Analysis is based upon the direct interpretation of this individual instance alone. The "instrumental" study, on the other hand, is chosen to answer a specific research question, and it is the underlying issue it exemplifies, rather than the case itself, which is important. Analysis is based on a search for patterns across a number of cases and for a refinement of understanding through what Stake termed "categorical aggregation of instances" (p.74). Thus case studies are of interest for both their uniqueness and their commonality but, as with the positivist approach, a single case as a negative example can limit generalizability.

Hamel et al (1993) similarly developed a twofold terminology in their view of the purpose of case study research, which was to move "from local to global" (p.34). Here, the case study was "only microscopic for want of a sufficient number of cases" (p.34) though the authors added that the number was not paramount providing each case was suitable for the aim. However, to Hamel et al (1993) the single case could also be seen as representative in its own right provided there was sufficiently detailed description, since this would lead to a clearer understanding and hence to explanation. The use of terms such as "explanation of its properties" (p.37) and

"relationships that link the parts" (p.39) is strongly suggestive of Yin's (1994) much more explicit view of subunits within a case.

Yin himself (1994) advanced the notion of generalizability in case study design through his idea of analytic generalization. The vast number of variables under study in comparison to the number of data points available has already been seen to make statistical generalization impossible, but generalization at the level of theory (rather than empirical data) becomes possible providing a theoretical framework is developed first. Yin outlined a number of strategies for achieving this and in multiple case study design the favoured approach is a two-stage process. The first stage consists of "pattern matching", whereby "several pieces of information from the same case may be related to some theoretical proposition" (Yin, 1994 p.25) and this strengthens the internal validity of the research where causal relationships are being examined. The second stage consists of replication logic, which is analogous to multiple experiments, where the results of the entire case are compared both with other cases and with the proposed theory. If predicted similar results occur, this is literal replication. If contrasting results occur for predictable reasons, this is theoretical replication. And if the cases do not produce results as predicted, then the initial theory must be revised and retested with another set of cases. An important point with replication logic is that data from subunits are not pooled across cases, but analyzed within cases prior to a cross-case analysis at the main unit level.

This approach seemed suitable for the study of case management. In many ways the research question and the case definition could be seen in terms of Stake's "instrumental" study, where the issue (case management practice), rather than the particular case, provided the focus. Findings from one case would also become more meaningful through the use of replication logic, use being made of both the literature already reviewed to develop a framework, and the findings from the survey stages to provide a number of suitable cases, thought to possess the characteristics under examination. However, both stages of Yin's analytic strategy need to be further detailed, and can

be discussed under the remaining two sections of his definition given above.

iii) Triangulation

The use of triangulation in order to undertake the "pattern-matching" analysis was said by Yin (1994) to strengthen the construct validity of the research - the establishment of the correct operational measures for the concepts being studied. Although Yin followed the commonly-accepted typology of triangulation (data triangulation, investigator triangulation, theory triangulation and methodological triangulation), his definition of these terms differed from other exponents. Yin (1994) advocated what he termed data triangulation for the case study, though his illustration of this on p.93 featured different methods (interviews, surveys, observation, records etc), equivalent to what Polit and Hungler (1999), for example, termed "method triangulation" (p 428). To Polit and Hungler, data triangulation implied one method (for example interviewing) but using multiple data sources (for example key informants). Powers and Knapp (1990) implied that both usages are acceptable, but made the point that there is no clear agreement on the meaning of triangulation in research and it is used in very different ways. Therefore, those who use the device must specify its meaning within their work.

The purpose, as well as the type, of triangulation in any research needs to be made clear, since it affects the logic of the overall design. Both Powers and Knapp (1990) and Redfern and Norman (1994) have pointed out a dual application here, namely confirmation and/or completeness. Confirmation occurs where data converge around a particular theory or proposition and strengthens its claim to be upheld. Where the aim is completeness, a method is selected for its unique contribution to the research question and assists in building up the picture through the highlighting of new, and different, theory. Yin (1994) appeared to follow the convergent theorists here in his illustration of convergence and non-convergence on p.93.

Yin (1994) suggested the "sources of evidence" suitable for case study research to be almost unlimited, and specifically discussed six sources - documentation, archival records, direct observation, participant observation, interviews and physical artefacts. Though he detailed their relative strengths and weaknesses, his conclusion was that no single source has advantage over the rest. Other writers on case study methods have adopted the same position and Hutchinson (1990) added that it is the depth and breadth of evidence supporting the case study, rather than a definitive method, which is important.

For case management research it was felt helpful to triangulate both data collection methods and data sources, with the object of convergence around the framework constructed from the literature. As noted above, semi-structured interviews were selected as the major feature, conducted with different key informants (data sources) from each case and covering the same issues as the initial questionnaire, but in greater depth. Additionally, documentation was scrutinized pertaining to case management practice within the case study site (mission statements, assessment forms, protocols etc). Observation, another data collection method common to the case study, was discounted on the grounds that case management practice would be difficult to define operationally, and sufficiently inclusively, for the purposes of an observation schedule. In addition, the inferences made from observed behaviour would leave too high an element of subjectivity in an area given to different interpretations. Interviews, on the other hand, would allow the respondent to speak within his/her own conceptualization of the phenomenon, and to make this explicit.

iv) Relationship to theory

To Yin, the relationship of the case study to theory development, made explicit in the last of his defining clauses, underpinned the assumptions underlying his other assertions about the method. The limitations of the scientific method, and a tendency by many researchers to view the case study as part of the naturalistic research paradigm, have already been noted at the introduction to this section.

Nevertheless, Yin's (1994) favoured analytic device of generalizing to some pre-formulated theory through replication logic strongly suggests an adherence to the positivist approach, a conclusion which is further enhanced by his reference to a similarity between the case study method and multiple experiments (section ii).

While Yin (1994) accepted that case studies may be descriptive in nature (indeed, the famous Street Corner Society of Whyte [1955] falls into this category) the emphasis in his writing was clearly on the explanatory case study. This, like the experiment, deals with "how" and "why" questions, as opposed to "who", "what", "how many" or "how much" questions, which deal with frequencies and incidences and are, therefore, more suitable to survey-type approaches. Questions alone, however, according to Yin, do not point to what a researcher should study and, therefore, there is a need to develop "propositions" about the research, which reflect an important theoretical issue. Only where a topic is the subject of "exploration" - and this condition may exist in experiments and surveys as well as case studies - does a study have a legitimate reason for not having any propositions, though, even here, there should be a clear purpose to guide data collection.

The role of theory development, prior to the conduct of data collection, is one point of difference, to Yin (1994), between case studies and related methods, such as ethnography and grounded theory, although, like these, the case study may also be used for theory-building. This, with other comparative parameters, is clear in his figure illustrating these methods (reproduced in table 2.3) which, with the additional property of contextual inclusiveness, makes the case study unique among research strategies.

Ultimately, of course, the question of theory development must be addressed by all researchers if one is to accept the received definition of research. And, interestingly, even the proponents of the ethnographic case study appear not so far from Yin's position when pushed to defend their logic on this point. Hamel et al (1993) commented that validating a theory is at the core of the methodological conflict, and advanced their own notion of

theoretical validation as a way of dealing with the inadequacy of the single case study as explanatory theory. While still holding that "all theories are ultimately based on a particular case or object" (p.29) the theory so produced may be validated by others to assess their general applicability. As with Yin, Hamel et al (1993) saw knowledge generated in this way as not based on empirical elements but on a set of proposals or abstract theories.

Table 2.3 Differences in assumptions among four evaluation methods
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Types of evaluation

	Case study	Ethnography	Grounded theory	Quasi-experiment
Design:				
1 Assumes a single objective reality that can be investigated by following the traditional rules of scientific enquiry	Yes	No	Yes	Yes
2 Can be used for theory-building	Yes	Yes	Yes	Yes
3 Also favours theory-testing	Yes	No	No	Yes
4 Considers context as essential part of phenomenon being evaluated	Yes	Yes	Yes	No
Data collection and analysis:				
5 Favoured data collection technique	Multiple	Participant observation	Multiple	Multiple
6 Type of data to be analyzed	Quantitative or qualitative	Mostly qualitative	Qualitative only	Mostly quantitative

Even Lawrence Stenhouse, one of the leading ethnographic researchers in the field of education, adopted an approach more akin

to historical research than ethnography in his discussion about moving from case material to theory (for example Stenhouse, 1984). Thus he wrote about multi-site research and both generating grounded theory and testing theory, while Burgess (1985), schooled very much in the Stenhouse tradition, encouraged the use of previous theories in new areas of research. One point thus almost universally accepted by case study theorists is that there is some relationship between the study and theory, be it theory-testing or theory-generating. Hutchinson (1990) has made a useful distinction between the case study and case history on this point, the latter often taking an atheoretical stance. She pointed out, however, that case histories are often claimed, erroneously, as case studies by their authors, and readers therefore need to be on their guard when reading nursing research making such claims.

In researching case management, use was made of the existant theory reviewed in the literature. Although this did not constitute grand theory on the scale often associated with discipline-specific research, Yin accepted that this would often be the case, and that lesser research findings could still be useful. Theory applied at two levels. Firstly, commonly used parameters for describing case management projects were adopted in structuring the descriptive elements of the interview schedule. In addition, recurring issues from the literature were used to trigger discussion where respondent perceptions on role value and appropriateness were required. Secondly, and more generally, the factors appearing as contextual variables in the literature, and hence as units of enquiry in the data collection plan, were, by their nature, instrumental in the construction of the theoretical framework for the whole study (already illustrated in fig. 2.4). The underlying "propositions", as Yin would term them, concerned the way in which these variables combined to address the research question, namely under what circumstances case managment may or may not be an appropriate role for nurses.

2.6.5 Ethical issues and obtaining approval

In case study research, as Hutchinson (1990) noted, the usual ethical considerations apply in terms of informed consent and freedom to

withdraw, and information sheets relating to these issues were prepared for all potential interviewees (Appendix II) as well as consent forms. The issue of confidentiality appears to be less clear. While Hutchinson (1990) suggested that case study ethics are more complex than those of most research, due to the multiple sources of data and the detailed description which may make single case studies identifiable, she nevertheless took confidentiality to be an ethical imperative. Yin, on the other hand, suggested that researchers have a choice and that generally "anonymity is not to be considered a desirable outcome" (Yin, 1994, p.144). Disclosure of identity, he suggested, produces two helpful outcomes. Firstly, it is helpful for the reader who may wish to integrate other information s/he may have about the case and, secondly, the entire case can be reviewed more readily, citations may be checked and criticisms raised. However, Yin (1994) also suggested occasions where anonymity is necessary, notably when the case study is on a controversial topic, where the final report may affect subsequent actions of those studied and when the case study portrays an "ideal type". Suitable compromises were suggested to cope with these, such as disclosing identity at case but not individual level.

It was thought best that this research followed the traditional rules of confidentiality, where participants are identifiable only to the researcher (see Appendix II). It would be unlikely that Yin's reasons for disclosure would apply, other than on the part of case study participants, who were not necessarily the intended main audience. Identifying broad geographical areas only would enable self-identification by participants if desired, without compromising their right to privacy from others. It is interesting that the classic case study by Whyte (1955) followed this format.

Applications were made on this basis to 17 local research ethics committees (LRECs) covering the 17 case study sites identified. Though all were ultimately successful, considerable difficulties and delays were experienced in achieving this and a wide variation in practices noted. All application forms were different and most reflected the type of information pertinent to a clinical trial, making them difficult to complete. The number of copies of the form (and

sometimes what was universally termed the "protocol") requested ranged from one to 14, and the length of time from application to approval from three to 22 weeks (table 2.4). A number of queries were raised by committee representatives prior to meetings, though many pertained to methodology (mainly relating to sample size and method of accessing respondents), rather than ethical issues as such

Table 2.4 Ethical committee details

Area	Number of copies required	Time from application to approval	Queries
1	10	5 weeks	
2	1	3 weeks	
3	12	19 weeks	sample/access
4	10	3 weeks	
5	14	19 weeks	sample/tapes
6	1	7 weeks	
7	10	12 weeks	sample
8	13	9 weeks	
9	11	11 weeks	
10	13	20 weeks	method/sample/ tapes
11	13	6 weeks	
12	10	9 weeks	
13	12	10 weeks	
14	12	22 weeks	access/tapes
15	1	11 weeks	
16	12	7 weeks	
17	6	7 weeks	

(though confidentiality of taped interviews was also of some concern). Further, some committee interests appeared distinctly unethical, such as the request from one for further details of the other 16 District Health Authorities covered by the research. However, many of the more minor issues were resolved either by letter or telephone discussion and only two requested the researchers' attendance in person at the meeting.

The experience appears to be not unique to researchers. Despite guidelines for the constitution and conduct of ethics committees from both the Royal College of Physicians (RCP, 1990) and the government (National Health Service Management Executive [NHSME], 1991), as well as academic circles (for example Foster, 1992), inconsistency has been well documented in practices around this time. Neuberger (1990) commented that, although the guidelines from the RCP were the toughest to date, there continued to be a marked lack of uniformity in styles of operation, possibly attributable to their advisory nature, since they have no power of enforcement. A postal survey of LRECs by the same author conducted for the King's Fund (Neuberger, 1992) found membership to be medically dominated, with insufficient nurse members and a variety of ways of processing applications. This latter point led to particular problems with multi-centred trials, necessitating the type of multiple applications which this research experienced. Neuberger (1992) recommended the formation of a national committee to deal with such proposals, with clearer powers of operation than the voluntary arrangement suggested as "sensible" by the government (NHSME, 1991), whereby one LREC would be nominated to consider issues on behalf of all the others involved in the study. The three main issues noted by Neuberger (1992) have appeared frequently in the academic literature of the health care professions. One edition of the British Medical Journal in 1995 carried reports from three authors (including a nurse) applying to between 13 and 162 LRECs (Garfield 1995, Middle et al 1995, While 1995). All were what the editorial described as "social protocols" - not clinical trials and mostly concerned with survey-type methods. The authors' experiences with multiple applications, diversity of practices and coping with medically orientated application forms prompted further

calls for some form of national ethics committee to oversee this type of research. Current practices have also been criticized by public health researchers (Ginzler et al, 1990) and nurse researchers (Hunt 1992, Mander 1992) where, again, studies tend to be non-experimental and often multi-centred. The overall consensus appears to be that some sort of reform is needed to facilitate research in these disciplines and, since this research was conducted, the NHSE (1997) has, indeed, issued a circular outlining the mechanism for such machinery.

Having received ethical approval, telephone contact was re-established with respondents at manager level, both to invite them to enter this phase of the study and to update the research database relating to community care developments. Managerial, and later practitioner, permission was granted at 13 of the sites approached, which were distributed across wide ranging geographical locations and specialisms as illustrated in table 2.5. Reasons for declining were given at both these levels and included factors such as

Table 2.5 Case studies by specialism and rate of attrition

Specialty	Original No.	No. declined	Final No.
Elderly (District nursing)	7	3	4
Mental health	6	1	5
Learning disabilities	4	0	4
Total	17	4	13

community nurses already being over-researched or no longer acting as case managers. Attrition through the power of veto by "gatekeepers" in nursing research has been noted by Mander (1992), though for different reasons to those experienced in this research,

which were felt to be largely understandable and acceptable (and perhaps a feature of the growth of research in nursing).

2.6.6 Pilot studies and main data collection

Data collection instruments consisted primarily of interview schedules as follows:

- Nurse manager interview schedule (Appendix III). This sought to elicit strategic details of each project's genesis and future direction.
- Nurse interview schedule (Appendix IV). This was administered to the community nurse case managers in the sample in order to elicit information with respect to the care of one client on:
  - role, in terms of the "core functions" of case management or equivalent stages of the nursing process, as appropriate
  - detailed nurse and client characteristics
  - services received by the client
  - professional preparation for the role
  - personal accounts of the quality of care delivered and ethical issues, particularly with respect to accountability, client advocacy and role boundaries/conflicts.
- Client/carer interview schedules (Appendix V & VI). These sought to elicit information regarding the perceived role of the attached community nurse with additional quality statements.
- Documentation, such as assessment forms and protocols, in current use within the case study sites.

A semi-structured format was considered most appropriate for eliciting information of sufficient depth which would, at the same time, guarantee coverage of issues highlighted in the literature.

Instruments were pilot tested at two sites (elderly and learning disabilities) with both researchers taking half the data collection at

each site, then cross analyzing data and experiences in order to produce optimal consistency of application, and quality and relevance of data recording. The exercise resulted in some changes to the interview schedules, including shortening and minor rewording. In addition, an established preference for interview order across the three respondent types was established (though not always possible, subsequently, to adhere to) and the client selection protocol was tightened in an attempt to reduce the difficulties encountered in trying to interview very disabled clients. Due to these necessary changes, data from these two sites were not included in the final analysis.

Following the granting of written, informed consent by all participating respondents, a total of 46 interviews were conducted over a period of 6 months during 1994, all but one being tape recorded with permission. The two researchers took 6 and 5 case study sites respectively, although one of the latter group was later redesignated as 3 separate case studies, for methodological reasons (see appendix VIII).

The distribution of respondents within each site varied from the full quota of one line manager, 3 case managers and 3 client/carer units (ie 7 interviews), to only one line manager and one case manager (2 interviews). Particular problems were encountered in securing good client interviews, mainly due to the partially anticipated problem of this group being the most highly disabled service users which may be expected to be targeted for case management. In addition, and mainly in the mental health specialism, clients originally agreed, but later defaulted, due to change of mind, forgetfulness, or simply not being at the appointed place when the researcher called. Where possible, carers were used as an alternative "consumer voice" and in a number of interviews, both carer and client were present, though in these, one or other was generally designated the "official" respondent. All respondents were thanked in writing after participation in the project and relevant GPs of clients were notified (as a stipulation of many ethics committee approvals).

In keeping with Yin's (1994) recommended tactic for maximizing reliability in the case study, all procedures were carefully documented, such that an external reviewer could reconstruct the research in reasonable detail and arrive at similar results. The entire process of case study conduct, from design through to data collection and analysis (detailed in the results section), was thus largely in keeping with Yin's (1994) recommended procedures, which provided a helpful framework. The final phase of the research comprised a longitudinal follow-up of the case studies investigated and will be described in the final section of this chapter.

2.7 Longitudinal follow-up

2.7.1 Introduction and rationale

The literature reviewed suggests a lack of long-term data on case management, with evaluative studies tending to be conducted over months, rather than years. Challis (1994a) observed that the relative newness of the concept by the mid 1990s meant that there was a lack of evidence on outcomes. His work, and that of others at the PSSRU (Knapp et al 1990, Challis et al 1995), has constituted one of the few exercises so far in tracing case management initiatives from genesis to mainstream functioning. This work suggested that practices necessarily adapt to changing external circumstances; for example, it was noted that case management arrangements outlined in the first year of a study often became less attractive by year three (Knapp et al, 1990) and that the skills of staff needed to be changed as a project moved from implementation to mainstream (Challis et al, 1995). In response to this lack of up-to-date evidence, Phillips and Penhale (1996), in their review of the literature, recommended more longitudinal studies be undertaken to answer some of the outstanding questions relating to case management, as it moves into the 21st century.

The work on nurse-led case management appears especially wanting in this respect (section 1.6), an omission which is of particular concern in the light of the policy changes initiated following the change of government in 1997 (section 1.3.6). There was thus felt to be a need

in this research to examine the "durability" of nursing ideals and practices in this area over time - an issue pertinent to any model under examination - and hence the determination of the fourth objective, which sought to address this issue. A longitudinal follow-up survey was felt to be the most appropriate means of achieving this end.

2.7.2 Defining longitudinal research

A variety of definitions of longitudinal research have been put forward over time. Moser and Kalton (1971), who used the alternative title of the panel method, defined it simply in terms of the collection of data from the same sample on more than one occasion. Polit and Hungler (1999), however, identified panel studies as but one type of longitudinal research, the others being trend studies, cohort studies and follow-up studies. In this typology, only panel and follow-up studies make use of the same subjects (the panel) to supply data over time, the latter being more commonly associated with experiments or other non-survey research, for example following some specific intervention.

A more comprehensive definition has been provided by Menard (1991), which allows for Polit and Hungler's (1999) typology:

> "Longitudinal research is research in which a) data are collected for each item or variable for two or more distinct time periods, b) the subjects or cases analyzed are the same or at least comparable from one period to the next, and c) the analysis involves some comparison of data between or amongst time periods".
>
> (Menard, 1991, p.4)

Menard (1991) identified three variants on the method within his definition. In prospective panel designs, data are collected at two periods, covering those periods; in retrospective panel designs, data are collected at a single point, but covering several periods; and in repeated cross-sectional designs, different cases are used for data collection. The type selected for this research was dependent upon the relative advantages and problems associated with each one.

2.7.3 Advantages and problems of longitudinal research

The two main advantages of longitudinal research, universally acknowledged, appear to be its value in studying changes or trends in some detail and the ability to determine the temporal sequencing of phenomena, essential for establishing causality (Moser and Kalton 1971, Polit and Hungler 1999, Menard 1991). Although causal issues were not the focus of this research, changes in case management practices were an issue. In addition, Moser and Kalton (1971) pointed out the administrative advantages of lower overhead costs of sample selection spread over time, and easier fieldwork planning (though these would presumably only apply to panel studies).

Further advantages have been identified by nurse researchers conducting a series of panel studies following the career paths of nurses and midwives (Robinson and Marsland 1994, Robinson et al (1999). One major benefit was found to be the analysis of change at the individual, or micro, level, as well as the aggregate, or macro level. Moser and Kalton (1971) equated this with the identification of the "changers" - which particular individuals change - in addition to the net changes over time in the whole sample, though this, again, is only possible if the same individuals are used over the period of the research. Since this research is concerned with the effects of variables not only at the macro (policy, organizational) level, but also at the individual (case manager) level, this was considered an appropriate approach to adopt.

However, these advantages are offset by a number of problems particular to longitudinal research, and especially panel designs. These include: the achievement of the initial sample, with agreement to respond over time (Moser and Kalton, 1971), conditioning of the sample (Moser and Kalton, 1971), the difficulties and expense of managing this method (Polit and Hungler 1999, Burns and Grove 1997), lack of standardization in the collection of data (Menard, 1991), the complexity of data analysis (Robinson and Marsland, 1994) and, the most serious problem, sample mortality (Moser and Kalton 1971, Polit and Hungler 1999, Burns and Grove 1997, Menard 1991,

Robinson and Marsland 1994, Robinson et al 1999). These issues will be addressed in turn as applied to this research.

Obtaining agreement of the initial sample would obviously be more problematic the greater the number of responses anticipated at the outset of the research. However, like the midwifery career project (Robinson and Marsland, 1994) the case management study was not initially set up as a longitudinal design. Thus obtaining initial commitment was not a problem, though this was counterbalanced to some extent by the difficulty of re-establishing contact with respondents after some time had elapsed. However, Robinson and Marsland (1994) managed re-contact rates of 63% and 70% with midwifery cohorts after 7 and 3 years respectively, so the associated problems are obviously not insurmountable.

Sample conditioning, where respondents may become untypical as a result of being on the panel, is an issue which also becomes more important with increasing numbers of responses and continued contact with the research. Again, these are issues which are less applicable to this project, and the topics under examination (related to whether respondents remained in case management practice) were of a nature unlikely to evoke a conditioned response.

Both Polit and Hungler (1999) and Burns and Grove (1997) suggested panel studies to be both difficult and expensive to conduct, however, they failed to elaborate on the claim, and the reasons for it are not clear. There is no obvious reason why a longitudinal design should incur greater expenses than repeated cross-sectional studies, other than, perhaps, the cost of maintaining contact between data collection tranches, and, as Robinson and Marsland (1994) found, the method has positive advantages in that sample details of background data, such as demographic variables and employment history, have already been collected. This observation applied to the case management sample.

Lack of standardization in data collection may arise for legitimate reasons, principally the changes that occur over time, making original outcome and other measures inappropriate or redundant (Menard,

1991). For example, in this study, details on models and processes of case management had aleady been elicited for each case study site, and the main subject of interest in the follow-up was whether respondents remained in the same role or whether changes had occurred.

Complexity of data analysis was mentioned by Robinson and Marsland (1994) as an issue in panel studies, though it should be remembered that their study of RGNs involved four data collection periods - at 6 months, 12 months and 4 years from qualification - with the need to analyze data from one period, prior to the next questionnaire mailing. In the case management study there was only one follow-up period, at some 4-5 years post-initial data collection. Menard (1991) implied that traditional methods of data analysis were applicable, with the additional feature of measurement of change (and, in intervention studies the evidence of causation) being important. In this research, it was planned that a simple, dichotomous (yes/no) choice of response should be used, thus avoiding the more complicated measurement of the magnitude of change inherent in the use of ordinal scales and equivalent quantitative measures.

Finally, and probably the most serious of the issues associated with panel studies, there is the problem of sample attrition, with its implications for generalizability (Moser and Kalton 1971, Polit and Hungler 1999, Menard 1991, Burns and Grove 1997, Robinson and Marsland 1994). According to Moser and Kalton (1971), sample attrition becomes an issue where follow-up is at one year or over, while Menard (1991) quoted levels of attrition at between 11% and 55% in studies over 8 to 17 years. However, Robinson et al (1999) found that high response rates could be encouraged through a number of strategies including: recruitment by personal visit, maintaining regular contact with respondents, ensuring user-friendliness of the questionnaire, the use of postage stamps, as opposed to pre-franked or freepost envelopes, and follow-up of non-respondents. A number of these strategies were adopted in the case management follow-up; initial, personal contact had been made with case study (though not original questionnaire) respondents, a short, easily-completed questionnaire was devised (see below, section 2.7.4), postage stamps

were used for both outgoing and return envelopes, and non-respondents were followed up, with a reminder letter and second questionnaire.

2.7.4 Questionnaire design and research strategy

It was decided that follow-up data should be elicited from respondents of both the second (questionnaire) phase of the research and from community nurses and their managers interviewed in the third (case study) phase. Two questionnaire templates were devised seeking information regarding five areas of concern: whether community nurses still worked in a case management-related role in that area; whether (if they did) the numbers had expanded, remained the same or declined; reasons (if not) for discontinuation; anticipation of likely future change in numbers; and an invitation to make any further comments (Appendices VIIa & b). Variations on the templates enabled a greater degree of precision and personalization of the questionnaire according to recipients (original questionnaire respondents or case study managers/community nurses), specialism (community psychiatric nursing, district nursing, health visiting or community learning disability nursing) and the title used to describe practice in the earlier phase (case manager, care manager, keyworker, care coordinator, care programme approach, shared care, joint care, care organizer, nurse assessor, out-of-hours emergency nurse). A template letter, with similar variations, providing brief details of the project and an invitation to participate, was also devised, with assurances of confidentiality.

The format of the questionnaire was designed to fit on one side of A4 paper, to encourage completion by people whose time was at a premium. At a minimum respondents would be required to tick 3 boxes, whether or not nurses were still engaged in case management-related practices, though opportunities were provided to expand on answers where applicable and desirable.

A total of 60 questionnaires were despatched in October 1998 to questionnaire sites, addressed to the current nearest equivalent person to the original recipient, with details being taken from the Handbook

of Community Nursing (1998). Of these, 42 usable returns were received by the end of the year, plus an additional 3 photocopied and completed forms, which one manager had passed on to other nurses working in the area. Two respondents requested further details, having not been in post at the time of the initial questionnaire, one enclosed an additional one-page detailed response on the subject, and a further one was torn, with information missing (presumably damaged in the royal mail sorting equipment). Reminders and a further questionnaire were sent to the 18 non-respondents, resulting in a response from 12 of these, by March 1999, including one who stated that an original questionnaire had not been received. Thus the total response rate was 54 out of 60, or 90%.

For the case study participants, questionnaires were sent to 13 managers and 16 community nurses, also in October 1998. Manager details were again taken from the Handbook of Community Nursing (1998), however, because the community nurse questionnaire asked whether they were still functioning in a case management-related capacity, it was important to locate the same individuals as those interviewed in the original data collection. Since names of individual practitioners are not recorded in the Handbook, a telephone survey was conducted and contact attempted with each original site. This was successful, with confirmation that 16 of the original 22 nurses were still employed within the same trusts. Response rates by the end of the year were 9 managers (69%) and 16 community nurses (100% of those sent, 73% of the total original sample). Since some response was available for each case study site, it was decided not to proceed with a reminder.

Analysis of the data comprised a simple summation of the responses in each category to the different questions and a breakdown according to type of respondent (phase of research, status, specialism). Comments were analyzed and used to supplement the quantitative data where appropriate. Findings thus helped to indicate the degree of change in case management practice since the initial data collection phases and the anticipated change in the near future.

3. Findings and discussion

3.1 Introduction

Results of the research are presented for clarity by breakdown into its component stages. Although each stage was designed to be self-contained, a degree of overlap is inevitable, because the results of one became the starting point for the next. The case studies, forming the main research focus, are detailed at the two levels - descriptive and theoretical - at which the analysis took place. The discussion section, which follows the results presentation, then takes a more unifying approach in looking for commonalities and links across the different methods.

3.2 The telephone survey

Results of the first two aims of the telephone survey (the identification of individuals informed on community care initiatives and willing to complete a questionnaire) have already been addressed at 2.4.5 of the methods section, in order to enable a discussion of the questionnaire survey method. Results of the second two aims are presented below.

3.2.1 Overview of current community nursing practice.

This was intended as a subsidiary aim only, since a fuller overview was anticipated in the results of the questionnaire survey. However, these data were thought to be worth analyzing, since, although superficial, they are of a wider coverage than was possible in subsequent stages.

Although questionnaires were despatched to only 98 health authorities, these represent those areas where community care initiatives involving nurses were most advanced. In many other areas negotiations with Social Service Departments (SSDs) were well under way and in others pilot projects were about to start, and the interviewers were invited to make contact again in the near future. In areas where there was little activity this was often either because SSDs were perceived as very much the lead agencies and, therefore,

the likely discipline from which case managers would be drawn, or else due to delays in community care planning caused by moves toward community health service Trust status and realignments of SSDs. Indeed, it was not uncommon to learn of earlier developments which had subsequently been "put on ice" on account of such upheavals.

Activity would appear to vary according to community nursing specialty. Of the 122 questionnaires channelled through 105 respondents, the majority went to those responsible for mental health (43) or generic services (34), while 15 were sent to community learning disability nursing teams, though nine respondents had knowledge of, and accepted questionnaires for, two services (table 3.1).

Table 3.1. Individuals receiving questionnaires by area of responsibility

Specialty	No.
CPN	43
DN/HV	34
CLDN	15
All 3	4
CPN/CLDN	4
DN/CPN	4
DN/CLDN	1
Total	105

Key:

CPN = community psychiatric nursing

DN/HV = district nursing/health visiting

CLDN = community learning disability nursing

In only a small minority of cases (4) was the questionnaire recipient responsible for all community nursing services and able to answer for

the totality of specialties. In the case of the generic line, most projects appeared to involve district nurses rather than health visitors.

3.2.2 Value of the telephone survey as a means of data collection

One of the main advantages of the telephone survey was the ability to cover a wide area over a relatively short timescale - a desirable characteristic for sample identification in a field where change is so rapid. It also elicited a high response rate once contact was made, though initial contact proved difficult in a number of cases due to consistent failure to obtain a reply, wrong numbers or lack of reply from secondary referral. In a small number of cases problems were encountered by "protective" secretaries who insisted everything be put in writing. Validity and reliability, as discussed above, were difficult to measure.

3.3 The questionnaire survey

The picture of community nurse involvement in case management was built up from a number of dimensions which follow the sequence of the questionnaire:

3.3.1 Client groups

Of the 76 projects identifying client groups (most involving more than one such group), the largest (n=32) were those with mental health problems (42%), with the elderly (n=26 or 34%), people with learning disabilities (n=9 or 12%) and physically disabled (n=6 or 8%) also featuring (table 3.2).

Minority groups involved in less than six projects included elderly mentally infirm (EMI), carers, children, adults and dementia sufferers (though some respondents may have included these groups within other classifications).

Table 3.2 Case management projects: client groups

n=76 responses (many projects covered several groups)

Group	Number of projects
Mental Health	32
Elderly	26
Learning Disabilities	9
Disabled (all ages)	6
Elderly mentally infirm (EMI)	4
Carers	2
Children	2
Adults	1
Dementia sufferers	1
Various (non specific)	7
Total	90

3.3.2 Nurse details

Details of community nurses, in terms of specialty, are largely a reflection of the client groupings (table 3.3). Thus of the 76 projects recorded, 40 involved community psychiatric nurses (CPNs, 53%), 37 district nurses (DNs, 49%), 16 health visitors (HVs, 21%) and 10 community learning disability nurses, (CLDNs, 13%). Amongst "others" identified were managers (3), school nurses (1) and practice nurses (1). Most projects had more than one nurse involved and 91% of them involved those at grade G, though all clinical grades from A to I featured in returns.

3.3.3 Functions of case management adopted

This question, requesting details of nursing practice, could be said to form the very essence of the survey, since it was anticipated that it would yield clues as to the likely future role for nurses within the case management framework. Because case management as a concept is subject to widely differing interpretations, the question centred on its core tasks as identified by official policy and expanded upon in

Table 3.3 Case management projects: nurse details. (Many projects covered several specialties and grades)

n=76

Specialty	No. of projects
CPN	40
District nurse	37
Health visitor	16
CLDN	10
Managers	3
Community nurse	2
(Day) hospital nurse	2
School nurse	1
Practice nurse	1
Total	112

key:

CPN=Community psychiatric nurse

CLDN=Community learning disability nurse

n=63

Grade	No. of projects
I	10
H	20
G	68
F	13
E	21
D	15
C	3
B	14
A	4
All	2
Managers	3
Juniors	1
Nurse/auxiliary	2

subsequent guidelines (DoHSSI, 1991a, 1991b). These tasks comprise referral/ assessment processes, care or individual programme planning (IPP), service delivery and case monitoring and review. Additional information was sought about budgeting and purchasing responsibilities. The 81 responses to this question are represented in table 3.4.

Table 3.4 Case management projects: nurse functions

n=81 (most involved multiple roles)

Function	No. of projects
Assessment	79
Planning	58
Delivery	76
Purchasing	11
Monitoring	71
Budget holding	22

Full time (F/T) in role - 16; part time (P/T) - 61; some F/T, some P/T - 2; not known - 2.

3.3.4 Other services involved

The question on other service involvement sought to elicit data on which agencies contributed to the other core tasks of case management involving nurses, in order to further clarify the model adopted. Of the 79 responding projects, a majority (n=75 or 95%) included social services, with others including voluntary/private agencies (n=28 or 35%), occupational therapy (n=17 or 21.5%), HAs (n=9 or 11%) and GPs (n=8 or 10%) (table 3.5). A further 16 agencies featured in 6 projects or less. In breaking down the functions of respective agencies it was found that social services, like nursing, were involved in all activities, but comparatively less in care delivery and more in purchasing/ budget holding. Voluntary/private agencies were also active in all areas, while HAs tended to be predominantly purchasers.

Table 3.5 Case management projects: other services involved

n=79 (most involved several services)

Service	No. of projects	Service	No. of projects
Social services	75	Other medics	3
Voluntary/private	28	Carers	3
Occupational therapy	17	Paramedics	2
Health authority	9	Community Health Council	2
General practitioner	8	Hospital consultant	2
Physiotherapist	6	Administration	2
Housing	6	Users	1
FHSA	6	Assistants	1
Psychiatrist	6	Researcher	1
Psychologist	5	Not known	1

FHSA = Family health services authority

3.3.5 Titles

Although the term case management has been used thus far as if it denoted some well defined concept, the literature suggests otherwise. It was therefore considered prudent to request titles from respondents

following their descriptions of ways of working. Clearly otherwise there is a danger that what might be considered as case management would not be documented, while some claims to the practice may be unwarranted.

As indicated above, it was decided to use the government's "core phase" framework as an analytic tool in describing case management practices, although, arguably, this does not, alone, necessarily differentiate case management from nursing process activities, where there may be, for example, no interagency working. It was, therefore, interesting to note the variety of titles assigned to what, according to the chosen framework, passed as case management. These included "keyworking" (31), "care programme approach" (25), "shared care" (24), "care management" (17) and "care coordination" (9). The designation "case management" itself was used by 12 projects.

3.3.6 Advantages and disadvantages

The final section of the questionnaire sought feedback, albeit somewhat subjectively, from practitioners on the relative merits and demerits of the model of care adopted. Suggested ideological aims of case management (gleaned from the literature) were offered as a starting point.

Eighty replies to this question were received. Most endorsed or reiterated the suggested advantages of coordination (57), individualized care (53), cost effectiveness (40), promotion of quality care (39) and advocacy (38). Of the open comments, the largest number (27) were concerned with effecting the functions of case management, particularly through improved, "one-stop" assessment procedures, and a large group (18) commented on promoting interagency relationships and trust. User involvement, efficient use of skill mix and the identification of service gaps were also noted several times. Finally, a number of professional issues were raised, including increased accountability, flexibility of practice and motivation, though the need for appropriate training and professional support appeared as important concomitants to these.

In identifying drawbacks, respondents were asked to comment from both a consumer and practitioner perspective. Drawbacks for clients included reduced quality of service, lack of choice, the low priority given to non-case managed client groups, gaps in provision, confusion regarding who to contact and coping with change. For staff the main problems appeared to be negotiation of joint working relationships with other agencies, the time consuming nature of the role and coping with the administration, change, resource constraints and work pressure.

3.3.7 Longitudinal follow-up

The 54 (90%) responses to the follow-up questionnaire described in section 2.7 represented the specialisms (according to managerial responsibility) as oulined in table 3.6.

Table 3.6 Follow-up responses according to specialism

[n=54 (+3) responses]

Specialism	Number
CPN (+3)	23 (+3)
DN	14
HV	0
DN/HV	4
DN/HV/CPN	4
DN/CPN	3
CLDN	3
DN/HV/CPN/CLDN	1
DN/HV/School nurse	1
DN/HV/CLDN	1
Total	54 (+3)

Key:

CPN = Community Psychiatric Nursing

DN = District Nursing

HV = Health Visiting

CLDN = Community Learning Disability Nursing

(+n) = number of additional copies completed by subunits within Trust

It will be noted that areas of managerial responsibility did not correspond with those of the original questionnaire; equivalence in this respect was difficult to achieve due to Trust restructuring and personnel changes taking place between the two data collection

rounds. Collated findings from the data analysis are presented in the tables and short comments which follow.

In response to question 1, about whether community nurses were still acting as case managers, a total of 41 (over 75%) replied positively (table 3.7). However this proportion was spread unevenly across

Table 3.7 Trust status regarding whether community nurses still worked as case managers

Specialism	CNs still CMs	CNs not now CMs	Not known
CPNs	21 (+1)	2 (+2)	0
DNs	6	7	1
DN/HVs	3	1	0
DN/HV/CPN	3	1	0
DN/CPN	3	0	0
CLDN	3	0	0
DN/HV/CPN/ CLDN	1	0	0
DN/HV/School Nurse	0	1	0
DN/HV/CLDN	1	0	0
Total	41 (+1)	12 (+2)	1

specialisms, with 91% of community pychiatric nurses (CPNs), for example, remaining as case managers, but only 46% of district nurses (DNs).

Responses to question 2 revealed that Trusts with CPNs as case managers had seen an overall rise in numbers in this role (table 3.8),

Table 3.8 Trusts with CNs still working as CMs: relative change in numbers over last 4-5 years.

[n=41 (+1)]

Specialism	Expansion	No change	Decline	Not known
CPN	16 (+1)	5	0	0
DN	3	3	0	0
DN/HV	1	1	1	0
DN/HV/CPN	1	1	1	0
DN/CPN	2	1	0	0
CLDN	0	3	0	0
DN/HV/CPN/ CLDN	1	0	0	0
DN/HV/CLDN	1	0	0	0
Total	25 (+1)	14	2	0

whereas other specialisms displayed a greater spread in their profile. That the three community learning disability nursing (CLDN) respondents should all indicate "no change", rather than expansion is, perhaps unsurprising in the light of the uncertainty in that specialism.

Of the 14 (+2) responses from the 12 Trusts where CNs were no longer working as case managers, the main reason given for discontinuation (question 3 table 3.9) was policy change (n=7). Those who enlarged on this response mentioned the end of a pilot project (2),

Table 3.9 Trusts with CNs no longer as CMs: reasons for discontinuation

[n=14 (+2) Respondents were invited to select several options)

Specialism	Change of policy	Not considered a nursing role	Postholder left	Post description/ title change	Other
CPN	2	1	0	0	(+2)
DN	2	0	0	0	5
DN/HV	1	0	0	0	0
DN/HV/ CPN	1	0	0	0	0
DN/HV/ School nurse	1	1	0	0	0
Total	7	2	0	0	5 (+2)

restructuring (2) and problems with social service funding/budget (2). The relatively large number (5) of DN responses giving "other" reasons is striking, and all of these volunteered the information that DNs had never in fact (at least to the respondent's knowledge) worked in a case management capacity! There could be many reasons to explain this apparent anomaly, including the possibility that, despite the care taken with the wording in the questionnaire construction, post holders receiving the follow-up questionnaire perceived case management differently from their predecessors (and it should be noted that 44 of the 60 Trusts receiving the follow-up questionnaire provided the name of a different individual from that targeted five years previously).

Question 4, concerning the anticipated future for community nurses in the case management role also produced some interesting findings (table 3.10). Encouragingly, 24 of the 50 Trusts indicated future expansion, with only one anticipating decline. Of the two main specialisms, however, the CPN group had a much higher proportion

Table 3.10 Anticipated future role for CNs as CMs

[n = 50 responses]

Specialism	Expand/be reintroduced	Remain the same	Decline	Unsure
CPN	14 (+1)	6 (+1)	0 (+1)	3
DN	3	3	0	3
DN/HV	4	0	0	0
DN/HV/CPN	1	2	0	0
DN/CPN	1	1	0	1
CLDN	0	1	0	2
DN/HV/CPN/ CLDN	1	0	0	0
DN/HV/ School nurse	0	0	1	0
DN/HV/CLDN	0	0	0	1
Total	24 (+1)	13 (+1)	1 (+1)	10

anticipating expansion than the DN group, where one third of responses anticipated no change and one third displayed uncertainty (those unaware of previous community nurses in the case management role, as mentioned above, failed to answer this question). Though small, the CLDN group displayed the least optimistic profile.

A large number (26) of respondents volunteered further information in response to question 5, which may be grouped broadly in line with the sections of the literature review, that is, focusing in a progressive fashion on national policy issues, professional (nursing) issues, local organizational and policy issues and individual (case management) project experiences.

Firstly, there were three references to the advent of primary care groups (PCGs) and their potential to advance case management for nurses, while a further two respondents mentioned the Partnership in Action agenda (DoH, 1998) and its ability to inform the debate. Other policy issues arising were the amalgamation of case management within the care programme approach policy and the issue of the purchaser/provider split, becoming smaller, but still occurring at the lower end of the professional hierarchy in social services as opposed to a higher level within the health service.

Secondly, four respondents (all from the CPN specialism) commented on the professional suitability of nurses as case managers. One felt that, while the case management philosophy was compatible with nursing, the practicalities ruled it out as an option. Three others felt it to be part of the CPN role, particularly with the advent of assertive outreach programmes.

The third group of comments concerned the local organizational and policy context which could either facilitate or inhibit the development of case management. On the positive side, three CPN respondents mentioned expansionist policies in terms of community mental health teams, and three respondents (one CPN and two DNs) commented on good interagency working in the area. A further one CPN and one DN respondent referred to a refocusing on dependent clients, which are often those targeted for case management, but also to the consequent heavy workload this produced. On the negative side, a CLDN respondent commented on the uncertain future of that specialism, and one respondent (with integrated responsibility) commented that unitary authorities had interfered with local initiatives that were taking place, making intergency relationships difficult.

Finally, a number of questionnaire responses enlarged upon their own particular case management-related project. Two CPN managers touched on the importance of budgetary control, while one from the learning disability specialism specifically mentioned that they had no budget. The term keyworker/keyworking was preferred by three respondents (two CLDNs and one CPN), two of whom stated that the keyworker could be from any discipline within the team. Other

comments related to interagency working included four DN responses talking of project partnerships with social services, one where DNs worked specifically as "community care advisers" and two emphasizing that nurses did not manage/employ social service care staff. A further CLDN respondent emphasized a similar managerial remit limited to health care only.

Overall the follow-up responses mirrored the first questionnaire round in terms of specialism, with a large number, particularly in the largest (CPN) group still employing CPNs as case managers and showing evidence of recent and anticipated expansionist policies. Where posts had been discontinued the main reason appeared to be a change in national or local policy. There was still (five years post-original questionnaire) much variation in interpretation of the terms case and care management and also of variation between community nursing specialisms in embracing its ideals. Major issues volunteered by respondents continued to focus on interagency working, budgetary arrangements, role definitions/titles and the influence of emerging national and local policies.

3.3.8 Summary of telephone and questionnaire survey findings

Findings from the first two stages of the research primarily addressed objective i) of the research (overview of the extent of community nurse case management), with preliminary data on objective ii), pertaining to various features of the projects.

- Indications were that practice varied according to community nurse specialism, with the largest number of projects covering nurses and client groups in the mental health field, followed by the elderly/district nursing and learning disability nursing; although there was some evidence of health visiter activity in case management, no discrete client group was associated with the specialism.

- Functions of community nurse case management centred on assessment, care delivery and monitoring. There was some lesser involvement in purchasing and budget holding, which were largely

felt to be the responsibilitities of Social Services Departments, who were involved in the majority of projects.

- The term "case management" was not universally adopted and a variety of titles was used to describe practice, including keyworking, care programme approach, shared care, care management and care coordination.

- Advantages of community nurse case management were said to include coordination, individualised and "seamless" care, cost-effectiveness, advocacy and user involvement. Drawbacks included lack of service choice, low priority given to non case managed clients, gaps in provision, change, time and work pressures and resource constraints. Issues related to quality of care and interagency working were both positively and negatively described.

- A majority of community nurse case managers still practised in the role at follow-up. This was a particular feature for mental health nurses, for whom there had been greater expansion over the intervening years. About half of the Trusts - again majoring on mental health - anticipated future expansion, with others anticipating "no change", and only one anticipating decline. However, the learning disability and district nursing specialisms displayed uncertain profiles. Open comments referred to the influences on practice of the four contextual levels previously identified (national policy, professional issues, local orgnizational arrangements and individual experiences).

3.4 The case studies - thematic analysis

Following transcription of interviews, each case was analyzed in its own right at two levels. Level one was a descriptive overview of the case based on factual information in response to, and structured on, the interview schedule (see Appendix VIII). Level two analysis consisted of a more in-depth, selected latent content analysis. This aimed to seek beyond the description, to what may account for how and why particular practices, at subunit and case level, did or did not work. This use of the case study was found by Askham and

Thompson (1990) to be successful in their study of home support for dementia sufferers. In the context of the model already depicted (fig. 2.4), this corresponded to an analysis of data pertaining to the different types of units of enquiry. Three of these, national policy, nursing theory and local practices (that is, contextual variables) were the foci of the literature review, while the empirical case data provided the source of evidence on the fourth type (individual practice). These were drawn from the questions which explicitly invited comment and opinion, and from unsolicited comments enlarging on descriptive responses, together with the evidence from local documentation. A breakdown of the stages for this analysis are detailed below.

Yin (1994) argued the need for a general analytic strategy in case study research, one of his preferred two strategies being a reliance on theoretical propositions, as outlined at section 2.6 (discussion of method) and, within this, a pattern-matching logic which "compares an empirically-based pattern with a predicted one" (Yin, 1994, p.106). Although Yin was unclear how propositions should be constructed, a reading of one of his examples (p.112) suggests they emerge following at least some degree of superficial analysis of cases. This was the strategy adopted in this research, making use of the study's previous questionnaire data, plus the descriptive level case analyses, together with the literature which underpinned collection of these data, to identify an initial set of variables which impact upon the relevance and value of community nurse case management. These variables are presented within a stucture/process/outcome framework in order to enhance their utility (table 3.11).

Two points need to be made about the construction of this framework. Firstly, the variables represent a reconstruction and rationalization of the parameters used to guide the questionnaire survey and the descriptive analysis, though the information to be collected was of a different nature from these stages. For example, the first headings designated "nurse details" in the former and "case manager status" in the latter contain details of specialism, qualification, grade, time/hours devoted to case management

practices, employer status/orientation. In the framework they are subsumed under the variables headed "community nurse specialist

Table 3.11 Variables impacting upon community nurse case management

Structure issues

Practice related
- Resource considerations
- Purchaser/provider division
- Advocacy
- Workload

Management & support related
- Organizational factors
- Accountability
- Preparation
- Clinical supervision

Process issues

Professional relationships
- Teamwork - relations with SS, vol.agencies etc.
- Communicating beyond the team & involvement in service development

Community nurse/case management theory & process related
- Differences between community nurse & soc. work case manager practices
- Community nurse specialist issues
- Acceptability of process of case management implementation & change

Outcome issues

Practitioner focused
- Professional status - uncertainties etc.
- Compatibility/differences between community nursing & case management

Client focused
- Quality of care & user involvement
- Needs - met & unmet

issues", "preparation", "resource considerations" and "accountability", to allow for the different (that is, more theoretical) nature of the anticipated, second level data. Secondly, the variables are not mutually exclusive, nor are they meant to be, as this becomes difficult where data link two or more ideas. For example, the suggestion that resources are not a problem where the emphasis is on brokerage as opposed to intensive working (Ryan et al 1991) may

appropriately be placed under either "resources" or "purchaser/ provider split" and a certain amount of discretion was allowed in the decision as to placement. However, the categories are considered to be collectively exhaustive, which was felt to be the more important feature.

This framework of variables was a useful starting point, but obviously in need of some refinement before it could be used as a theoretical underpinning for analysis as Yin envisaged. Because of the importance to case study research of context, as already discussed, it was decided that a multi-stage pattern-matching process should, as its first stage, embrace the contextual variables previously outlined in order to identify a set of propositional statements, which would provide the theory against which to compare case data. Thus stage one consisted of "matching" the structure, process and outcome variables with issues emerging from the analysis of contextual variables (national policy, professional theory and local practices), equivalent to the findings from the reviews of policy, nursing and case management literature. This necessitated a re-reading of these reviews, noting and tabulating points of relevance and associated references under appropriate headings (table 3.13).

This table provided a basis from which to construct (stage two) a set of eighteen related propositions, grouped under five main headings (table 3.14). This process entailed synthesizing the findings from the three sources which were, in most cases, either complementary or corroborative. Although the quantity of data under each heading varied between the different sources, there was little directly contradictory evidence as such, although ideals put forward in policy were often not realized in practice. Where contradictions did occur, these were mainly between different individual case management projects and often explained by the model adopted or specialism in question. The emerging propositions were, as far as possible, framed with these limitations in mind.

Stages three and four pertained to single-case analysis and proceeded in an iterative mode. First (stage three), interview scripts and documentation for case 1 were scrutinized manually for data

pertaining to the propositions and coded (using highlighter pens) accordingly, along with evidence covering additional topics. Secondly, relevant data were transferred, either verbatim or in summary form, to tables under the main propositional groups, coded for source to maintain confidentiality. Thirdly (stage four) a commentary was written covering the degree of congruence between the within-case evidence (that is, between sampling units) and between the propositions and the whole case data. These stages were then repeated for cases 2 to 11

Yin (1994) has written at some length on both the types and the precision of pattern-matching within the case study design and these two issues merit some consideration. One of the more potent designs within the pattern-matching approach, because of its derivation from the quasi-experimental paradigm, is where the pattern is derived from nonequivalent dependent variables. According to this design "an experiment or quasi-experiment may have multiple dependent variables - that is, a variety of outcomes. If, for each outcome, the initially predicted values have been found, and at the same time alternative "patterns" of predicted values ... have not been found, strong causal inferences can be found" (Yin, 1994, p.106-7). Although the meaning of the term "values" is not made explicit, the accompanying illustration (Yin, 1994, p. 107) suggests these are equivalent to independent variables. It was initially thought this approach would provide a useful strategy for this research, yielding evidence that community nurse case management resulted (or not) in certain outcomes, along the lines of the propositions. However, Burns and Grove (1997), in likening this approach to the single group pre-test-post-test design, inferred the need for some form of pre-testing in order to be able to claim causal links, a point not made explicit by Yin. No pre-test (which would entail collecting evidence prior to case management implementation) was conducted in this research, for both pragmatic and feasibility reasons.

A second approach to pattern-matching, based on "rival explanations as patterns" (Yin, 1994 p. 108), comprises a focus on independent (rather than dependent) variables, in a search for a consistent pattern to explain a certain type of outcome. This would seem to preclude a

pretest, since the research is conducted retrospectively, when the outcome, across a number of cases, in known. The approach is less like a single case experiment, since the independent variables have not been identified prior to data collection and, therefore, are not amenable to manipulation. It would, therefore, seem to be more appropriate to this research, becoming especially relevant at the cross-case analysis stage. Differences between the two pattern-matching strategies, as interpreted here from Yin's (1994) description appear in table 3.12.

Table 3.12 Differences between two types of pattern-matching

Features	Non-equivalent dependent variables as a pattern	Rival explanations as patterns
Number of cases	single	multiple
Number of dependent variables (outcomes)	multiple	single or "global"
Number of rival explanations (independent variables)	small	large
Pretest	yes	no
Research conduct	concurrently, based on identified "intervention" or independent variable	retrospectively, based on identified outcome or dependent variable

With regard to precision of pattern-matching, Yin (1994) has commented that "at this point in the state of the art, the actual pattern-matching procedure involves no precise comparisons" and that "this lack of precision can allow for some interpretive discretion on the part of the investigator ... one wants to do case studies in which even an "eyeballing" technique is sufficiently convincing to draw a conclusion" (Yin, 1994, p.110). This need for "interpretive discretion" was certainly supported in attempting to move from case respondents' associational comments regarding a proposition, to their categorization. Firstly, statements did not always directly support or contradict the propositions due to the nature of the interviews, which at the time had naturally not been framed around these specific

statements. However, it was felt that with a minimum amount of discretion, the substance of most statements could be acceptably classified. For example the manager in case 1, in stating "this whole process ... takes 3-4 hours to go through the paperwork" (M001) was implying support for proposition 5A, about the inadequacy of time.

Secondly, as previously highlighted, there was variation in the number of respondents between cases, so the amount of evidence upon which to make categorization decisions obviously also varied. For example, case 1 only had two interview respondents (one manager, one community nurse) compared to case 4, which had nine (manager, three community nurses, three clients and two carers) over seven interviews. However, this still allowed for Yin's (1994) "eyeballing" technique, as no quantitative comparative conclusions were being drawn.

Thirdly, the issue of congruence between respondents, or between statements made by the same respondent at different points of the interview, within a case needed to be dealt with. For example, the manager in case 1 mentioned an inability for case managers to meet needs ("carers are doing more and more and not getting the support they need" M001), which did not suggest there were strategies in place to offset instances of unmet need as put forward in proposition 5C. The community nurse, on the other hand, felt that so far needs, as opposed to wants, had been largely met, through "compromise and talking the client through how they feel ... " (N002). This suggested support for the same proposition.

Finally, there were found to be instances of no comment being made regarding a proposition, where data were incomplete, inadequate or unclear. An example of this is the lack of data about clinical supervision and accountability in case 2 (due in this instance to faulty recording of the interview).

Clearly there needed to be a facility to accommodate this variety of responses in relation to the propositions within stage 4, in order to indicate the significance of the commentary. Therefore a number of symbols were used following each statement as follows:

✓	data support the proposition	x	data do not support the proposition
±	data lack congruence	-	data do not mention point

Other abbreviations used were as follows:

CC	Community care	HA	Health Authority
CM	Case management/manager	HV	Health visitor
CN	Community nurse/nursing	LA	Local Authority
CPA	Care Programme Approach	LD	Learning disability
CPN	Community psychiatric nurse/nursing	MH	Mental health
CPT	Community practice teacher	OT	Occupational therapist
DN	District nurse/nursing	SW	Social work/er
		SS(D)	Social Services (Department)

Originally it was thought that there may also be a need to introduce a facility to cope with additional comments, not readily classifiable. In practice, however, this was largely unnecessary, since most remarks related to at least one proposition. The one exception was the regularity with which comments about degree of job satisfaction appeared (see later case data), which did not sit consistently within any category, since the contexts of the comment varied. They were therefore placed under various headings, to be readdresed at the cross-case stage as an independent issue. An issue which posed far greater problems for the researcher was that of minimizing the raw data presentation, both to maintain relevance and to adhere to an overall acceptable word limit for the thesis. Thus a number of highly illustrative phrases, used by respondents, were, unfortunately, sacrificed if a paraphrase conveyed the point more succinctly, or the point was duplicated elsewhere. This is one of the inevitable problems for a researcher faced with the task of reducing vast amounts of data. However, overall, there emerged what amounted to a means of quantifying, however crudely, the responses within the case data to the complete set of propositions and, ultimately, of facilitating cross-case analysis. This was presented in tabular form to illustrate the cross-case discussion. (See table 3.17 in the next section).

Table 3.13 Pattern-matching (1) Matching contextual variables

Issue	Data sources		
<u>Structural issues</u>	Policy literature	Nursing literature	Case management literature
Resources	Doubts existed over adequate resourcing of community care (Healy 1993, Henwood 1995, Johnson 1993, Smith 1993). Particular problems were thought likely over funding of community care (DoH 1989a), CPA (Hudson 1993), mandatory assessment (John Grooms 1989).	Constraints were thought likely to lead to conflict eg workload vs. fufilling ideals (Kitson 1997a, Luker 1997, Perry 1993, Smith 1992, Wade 1995).	There was evidence in some projects of lack of time (Meethan & Thompson 1993), resources (Baldwin 1995, Dant et al 1989, Pearson undated, Wilson 1993), services (Bland 1994) leading to compromise between ideals & reality (Meethan & Thompson 1993). But others found resources in general not a problem (Baldwin 1995) or under certain conditions eg where intensive model applied (Archer & Robertson 1990) or where emphasis was on brokerage as opposed to intensive working (Ryan et al 1991).
Purchaser/provider split	There were marked differences between the macro-purchasing of HAs & micro-level of LAs and CM should be purchased as part of the wider service contract (Challis 1994a). There was some suggestion of a need to separate purchasing/assessment and provision (DoH/SSI 1991a, b) though policy was ambivalent (DoH 1989a). Separation may lead to loss of continuity (Challis 1994a,b,c). Some interpreted CM as a purchaser role (Onyett 1992, Papadopoulos 1992), others as mainly provider (Onyett & Malone 1993). Others felt this division was too simplistic, as levels of separation exist (Peck 1992, Challis 1994a,b,c). There are advantages in budgetary devolution (DoH 1989a, 1990, DoH/SSI 1991a,b, SSI/RHA 1993b, NHSE/SSI 1994), though not necessarily to practitioner level (Rachman, 1995) as Warner (1990) & Challis (1994a) recommended.	There was much debate over whether provision is an essential part of nursing role. On the one hand nurses are usually seen as providers (Hunter, 1988), with emphasis on relational skills associated with provider work eg communication (Wright 1995, Cutliffe 1997), teaching (CNOs 1993, Bentley 1993), counselling (Knollmueller 1989, Repper & Peacham 1991), support (Torrence & Jordan 1995). Further, nurses experience difficulty seeing assessment as separate from provision (Bergen et al, 1996), are inexperienced in marketing (Murdock, 1995) and find responsibility for financial asessment has a negative impact on the therapeutic relationship (Kelly 1997). On the other hand nurses are seen primarily as being responsible for care but not actually providing (Bond, 1993), or that only care practitioners, not "G" grades should deliver care (VFMU, 1992). Involvement of nurses in micro-purchasing was seen as essential, if	Difficulty was found in separating purchaser & provider functions (Wilson, 1993), more so at micro than macro level (Challis et al, 1995). CMs in most projects were not greatly involved in provision (Challis et al 1990, Challis & Davies 1986, Thornicroft et al 1993, Richardson & Higgins 1991, Ross & Tissier 1994,1997).

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Purchaser/provider split (cont)		problematical where they are employed by providers (Thomas 1994). Opportunities exist for nurses in commissioning (Barton, 1995) & coordinating resources (RCN 1997, and in economic evaluation of work (Gournay & Brooking, 1991).	
Advocacy	Policy recommended an independent advocate in parallel with, rather than integral to, CM (DoH/SSI 1991a,b). There was some feeling that combining advocacy & CM would involve conflict (Peck et al 1992, Orme & Glastonbury 1993), though North (1993) suggested advocacy may feature in CM if not budget holding.	Advocacy is often seen within nursing remit (Thomas 1994, Cutliffe 1997, Joint Committee 1997) but it may involve potential conflict of interest (Dyer 1991, Morrison 1991, Marshall 1991, Sutor 1992) and diverse definitions have led to confusion about the role (Bennett 1999). Nurses may have difficulty in being sufficiently independent to perform an advocacy role (Hunter 1988) or object to the "professionalization" of an intrinsically nurse-compatible value system (Mallick, 1998).	The advocacy model of CM has positive aspects and is a natural extension of the role (Ryan et al 1991) eg in negotiating & counselling (Dant et al 1989). But it may limit service provision & some CMs are unsure whether it is part of the role (Baldwin 1995). Also, tension existed in combining CM & advocacy when CM was working from a budget-holding base or statutory authority (Richardson & Higgins 1991, Ryan et al 1991, Hudson 1992, Knapp et al 1992, Bland 1994). It was sometimes seen as a separate role performed by a third party (Meethan et al, 1993).
Workload	The debate over "targeting" vs. "universal CM" (DoH 1989a, DoH/SSI 1991a) led to fears for ever increasing CM workload with the latter (George 1993a) if no limit was set to new referrals (SSI/RHA 1993b). Orme & Glastonbury (1993) suggested a ceiling to workloads should be set.	Conflict was noted between constraints in practice, such as workload, and ideals (Smith 1992, Perry 1993, Wade 1995, Kitson 1997a, Luker 1997).	Examples were found of high caseloads with no extra budget (Pilling 1988), demand outstripping supply even with targeting (Ryan et al 1993), CM activity in addition to existing workload leading to pressure and staff suffering "burnout" getting a project established (Challis et al 1995, 1998). CMs resented time spent on admin. (Wilson 1993, Lewis & Glennerster 1996). Challis & Davies (1986) suggested that manageable caseloads, as in the PSSRU projects, may be unrealistic when mainstream.

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Organizational factors	Central government left responsibility for defining health and social care responsibilities to local level (DoH1989a) and policy interpretation to individual responses and judgements (Caldock 1994, Lightfoot 1995, Roberts & Priest 1997). Challis (1994a) emphasized the need for logical coherence in CM planning through horizontal integration at the practice level and vertical integration at the system (interagency) level, thus linking central, local & "street" levels. He also noted (p.16) "the needs of effective practice do not always lead to organizationally neat solutions".	Nursing is subject to controls imposed by the health care system and nurses must ensure structures are in place to allow its practice (Bond 1993, Rodgers & Fry 1994, Morrish 1995).	Health personnel were found to be disadvantaged by the national organizational framework (DoH 1994a) and some CMs had an organizationally unclear role (Challis 1994b). To be effective CM needs to be part of the logic of overall services (Challis et al 1995) rather than yet another management layer imposed on the local care system (Bland 1994). This entails strategic planning, though delivery of services may be negotiated at the level of individual initiatives (Archer & Robertson 1990).
Accountability		Nurses are individually professionally accountable (UKCC, 1992b, DoH Nursing Division 1989). Accountability is to patients/clients, carers, taxpayers, voters (CNOs 1993), to professional discipline, team members and the population (NHSE 1993) and will increase.	Many projects based on increased accountability (Challis 1986). Accountability is at 4 levels: interagency, interprofessional, coordinating care and coordinating activities and involves different lines of accountability, which may be problematical where team leaders are of a different professional orientation to CMs (Challis et al 1989). Accountability is less of an issue when CM is performed by existing services (Challis 1994b).
Preparation	There is need for appropriate training for CM (DoH 1993) though much was left to local interpretation (DoH/SSI 1991a & b). This would initially be "learning by doing" and would be of varying levels for different staff involved (DoH/SSI 1991a & b). Some concern for adequacy of preparation (SSI/RHA 1993a, Rachman 1995).	There is a need to invest resources into educating nurses for CM (Kemp & Richardson 1994, Millard 1995, Hatfield & Mohamad 1996), but debate as to whether this should be at first degree level (Revely & Walsh 2000) or masters level (Conger, 1999).	Projects noted a need for CM training even for experienced staff (Challis & Davies 1986, Brittian 1992) which should be joint & at agency and "street" levels (Meethan & Thompson 1993). This varied from "learning by doing" (Meetham & Thompson 1993) to one week induction followed by specific training (King 1990) to 8 week induction

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Preparation (cont)			(Ford et al 1993). For some there was no specific training (Askham & Thompson 1990) or it was felt to be inadequate (Wilson 1993).
Clinical supervision	Responsibility for supervision was left to local interpretation (DoH/SSI 1991a & b). There was some concern for the adequacy of supervision (SSI/RHA 1993a, Rachman 1995).	Clinical supervision is assuming increasing significance, especially in MH & LD and is central to the expansion of the scope of nursing practice (NHSE 1993). All primary health care nurses should have access to support from an experienced practitioner in the same field of practice (NHSE 1993). Though perceived as beneficial by nurses, it assumes low priority (Malin 2000)	Experience from CM projects suggests the need for adequate clinical supervision (Ford et al 1993, Pearson undated). However, Ford et al (1993) found service managers were seen as remote and lacking commitment.
Process issues Teamwork	Policy stressed merits of health & social agencies working together (as in PSSRU projects) with all agencies being brought into the assessment procedure (DoH 1989a), though definitions of health & social responsibilities were left to local agreement. This was supported ideologically (NAHAT undated) and in some practice especially learning disability & primary health care (Ovretveit 1993, Burton & Kelloway 1995) and in localities with a history of good collaboration (Henwood 1994). There was varied success in integrating GPs into new structures (SSI/RHA 1993b). But policy also suggested health & social care were 2 separate & separable entities (DoH 1989) and traditional, cultural, structural & educational differences were noted (Beardshaw & Towell 1990, DoH/SSI 1991a,	Coordination is important to nursing as well as CM (Ovretveit & Davies 1989, Ethridge & Lamb 1989, Hudson 1991, Hancock 1992, Kemp & Richardson 1994) and NHSE (1993) suggested nurses currently displayed interprofessional respect & understanding. However, evidence exists of poor multidisciplinary collaboration at service delivery level (Higgins et al 1995, Sibley 1997) and in joint assessment (Korczak 1993). Professional boundaries between health & social care are fluid (Carlisle 1992, Gournay 1992, Higgins et al 1994a, Joint Committee 1997, Leifer 1997, Warr et al 1998) and attempts to assign health & social needs to categories do not address problem of meeting needs at boundaries (Worth et al 1995). Culture gap between agencies makes collaboration less likely (Hudson 1991,	Most projects reported problems with interagency relations (Pilling 1992, Challis 1994b). Causal factors were numerous: resources (DoH 1994c), tensions in the health/social care agency divide (Meethan et al 1993, Challis et al 1995, Ross & Tissier 1997), objection to nurses as assessors & CMs (Challis et al 1995), lack of networking skills (Challis 1994b), small-team personalities and "anti-project" mentalities (Dant et al 1989), territorialism & boundary disputes (Dant et al 1989, Archer & Robertson 1990, Wilson 1993, Waterman et al 1996), misunderstanding from mainstream staff (Lieberman 1990). Problems apparent with DNs & HVs (Dant et al 1989) CPNs (Ford et al 1993) and in MH & LD multidisciplinary teams (Lewis & Glennerster 1994). However there were some examples of good

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Teamwork (cont)	Audit Commission 1992, Orme & Glastonbury 1993). This would lead to narrow definitions of responsibilities (Wistow 1994), disincentives to collaboration (Hunter 1993a, 1994, Lightfoot 1995), cost shunting (Hunter 1993a), competition rather than collaboration (Caldock 1994) & unclear boundaries between health & social care (Robinson & Wistow 1993, Henwood 1995, Richardson & Pearson 1995). Better joint working was found at strategic than individual CM levels (Caldock 1993, NHSE/SSI 1994, Lewis & Glennerster 1996), though where personal links were found, they were between community nurses and the local social work team (DoH 1994b).	Higgins et al 1994b, Worth et al 1995, Brothwood 1997) and professional adherence to "implicit knowledge" militates against shared understanding (Nolan 1996). Sines (1991) recommended model of care avoiding these demarcation lines.	collaboration (DoH 1994c, Higgins 1994, Peck 1992). Bland (1994) saw advantages where health and social workers were in the same team with the same CM role and Chambers (1986) felt GPs were also essential to CM. Challis et al (1995) called for more research on the health/social care interface at the micro (practice) and macro (agency) levels.
Service development	There was some feeling that community nurses may be key players in community care and should grasp opportunities to enhance their role (Podmore 1992, DoH/RCN 1993, Hockey 1995). But others thought nurses are unable to influence policy (Antrobus 1997) especially where case management is linked to a provider, rather than an independent agency (Papadopoulos 1992).	Nursing involves policy and purchasing contributions at all levels (DoH Nursing Division 1989, NHSME 1993, Joint Committee 1997). Kitson (1997a) felt nurses should rise above constraints, take control of systems and be involved in strategic planning at national and local levels.	Some projects found perceived or actual lack of case manager involvement in organizational planning (Ford et al 1993, Meethan et al 1993).
Community nurses vs. social workers as case managers	Policy suggested that CMs would be predominantly from a social service orientation, but this was not prescriptive and community nurses may well assume the role (DoH 1989a, SSI/RHA 1993b, NHSE/SSI 1994). This was supported by literature in	Fluid boundaries exist between health and social care disciplines (Carlisle 1992, Gournay 1992, Higgins et al 1994a, Joint Committee 1997, Leifer 1997, Warr et al 1998), resulting in discussions about disciplinary substitution (Huxley & Kerfoot	In some projects all CM professionals had similar roles (Peck 1992, Bland 1994, Pearson undated). In others there were differences: CPN emphasis on non-acute vs. SW emphasis on acute (Lewis & Glennerster 1994); DN part-time CM with team leader

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
CN vs, SW as CM (cont)	the fields of learning disability (McNally & Rose 1994) and social work (Orme & Glastonbury, 1993).	1992, CNOs 1993, Luker 1997) or the possibility of hybrid health/social care workers (Carlisle 1992). Morrish et al (1995) suggested it may be difficult for non-social workers to become CMs and Millard (1995) found acting as CM more like social work than community nursing. Sines (1991) recommended a CM model which avoided demarcation lines.	role & only CM for certain clients vs. SW full-time (Ross & Tissier 1994, 1997). Also nurses had fewer referrals/assessments (Peck 1992, Ross & Tissier 1994, 1997) and less supervision (Pearson undated) than SW.
Specialist issues	Mental health nurses were most affected by specialist policy; Section 117 (Mental Health Act 1983) and Care Programme Approach (DoH 1990b) recognized the appointment of CPNs as key workers. However Onyett (1992) and Hudson (1993) saw a danger of medical dominance, while White & Brooker (1991) feared CPNs may be deskilled for chronic illness work under CPA. Government also commented on effective coordination work by Macmillan nurses (DoH 1994b).	Various nurse specialisms were seen as compatible with case management including mental health (Repper & Peacham 1991, Gournay 1992, Sandford 1995, Dawber 1997), district nursing (Brittian 1992, Sisson 1995) and learning disability (Hudson 1991, Sines 1991).	Projects included nurses from different specialisms, most frequently: CPNs (Henderson 1990, Trotter 1992, Muijen et al 1994, Cahill unpublished), DNs (Fry 1992, George 1992, Peck 1992, Brunnen & Korczak 1993, George 1993c, Ross & Tissier 1994, 1997, Pearson unpublished, Stokes 1998), HVs (Murphy & Rodrigues 1992, Squire 1993, Lieberman 1996). More CPNs worked in multidisciplinary team, with DNs and HVs working either with a SW or based in general practice. Few examples of care provision in any specialism (George 1993c [DN], Muijen et al 1994 [CPN], Lieberman 1996 [DN/HV]).
Implementation and change	Government allowed for local interpretation of policy implementation (DoH 1989a) which may give rise to "implementation deficit" (Trnobranski 1995) and "street level bureaucracy" (Lipsky 1980) - much discretion on the part of individual practitioners. However Rachman (1995) attributed stress to the "top-down" way policy was implemented. Change itself caused	Nursing is shaped by contextual change (DoH Nursing Division 1989, NHSE 1993, CNOs 1993, Joint Committee 1997, Kitson 1997a, Luker 1997) and criticized for concern with government's agenda for change rather than nursing agenda (Wright 1993). But also shaped by changing disciplinary theory, often defined by practitioners themselves (Nolan & Chung	Projects suggest there is a need for a conceptual framework to introduce CM smoothly (Lewis & Glennerster 1996) with involvement of staff at all levels - agency, professional, front-line (Beardshaw & Towell 1990, Beardshaw 1991). Difficulties exist where implementation is "top-down" (Meethan et al 1993) or there is lack of clarity in project aims (Pearson undated).

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Implementation and change (cont)	insecurity & anxiety (Caldock 1993, Hunter 1993a).	1996). There exists a tension between organizational constraints and ideal practices (Smith 1992, Perry 1993, Wade 1995, Kitson 1997a, Luker 1997).	
Outcome issues Professional status	3 issues: Professional vs. user power, with professional as ultimate decision-maker (DoH 1989a, 1990); whether CM is a profession in its own right, which may undermine other professionals & lead to fear that practice is being eroded (Malin 1994, Davies & Connolly 1995, Rachman 1995); effect on CNs, promised "very significant role" in policy (DoH 1989a), but also a fear that role descriptions would tighten & services withdrawn where labelled "social" (Lightfoot 1995), thus need to regain confidence & skills (Sylvester 1992).	Nurses fear role erosion (Brittian 1992, Morrish et al 1995) & need to justify their existence & defend their territory, due to overlap with other disciplines (Repper & Peacham 1991, Gournay 1992), policy to deregulate areas of professional activity (Shaw 1993), culture of managerialism (Hatfield & Mohamad 1996) and the market (Bovell et al 1997), & debate continues about professional power/role boundaries (Rodgers & Fry 1994, Wright 1995).	Some projects found that where social services was lead agency, health staff tended to be absorbed into SW culture (Knapp et al 1992). There was also some fear of professional de-skilling (Baldwin 1995), leading to a need to preserve professional identity in a culture which was changing from a professional to managerial emphasis (Lewis & Glennerster 1994). However Trotter (1992) found skills were enhanced rather than diluted.
Compatibility of CM and CN	Government clearly saw CNs as suitable CMs, especially where health needs predominate (DoH 1989a, DoH/SSI1991a, b, DoH/RCN 1993, SSI/RHA 1993b), though Warner (1990) noted CNs only warranted one paragraph in draft guidance. Many noted room for variation in policy interpretation of CM role (Beardshaw & Towell 1990, Peck et al 1992, Orme & Glastonbury 1993, Challis 1994a), leaving place for professional, as well as managerial emphasis. Some saw CNs suitable in particular circumstances eg therapist-cum-manager model (Papadopoulos 1992), in assessment (Johnston 1993) or if not taking on provider	Certain modalities of nursing resemble CM eg primary nursing, named nurse, managed care, critical pathways, keyworking (table 1.3). Nursing also has comparable aims, client groups and values (table 1.2). Phases of the nursing process are similar to those of CM - assessment (Carlisle 1992, Gilbert 1993, Korczak 1993, Kelly 1997, RCN 1998a), care planning (Ovretveit & Davies 1989, CNOs 1993), evaluation/monitoring (CNO 1977, Ethridge & Lamb 1989), management (Ovretveit & Davies 1989, NHSE 1993, Ong 1995, CDNA 1995b, RCN 1996). Nursing is also adaptable (NHSE 1993, Joint Committee 1997). But nursing is	Many project evaluations suggest CNs to be suitable CMs eg DNs & HVs (Brittian 1992, Pearson undated, Ross & Tissier 1994, 1997), CPNs (Lear et al 1991). Certainly CM is better suited to existing professionals (Hunter 1988, Dant et al 1989) rather than an independent individual (though some users are indifferent to the designation of CM - Robertson 1995). Some professionals feel they have "always been doing CM" (Ryan et al 1991, Bland 1994). But Challis et al (1995) felt nurses are too focused on nurse-patient contact for CM and Wilson (1993) found CPN CMs' professional loyalty was to psychiatric nursing rather than to community care.

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Compatibility (cont)	role (QNI 1990).	more than a set of functions (RCN 1993a, 1995) though CM may be considered this. Adherence to title "nurse" may militate against assuming CM. Transerring skills is not easy due to different professional (SW and health) cultures (Higgins et al 1994b).	Further, few models of CM are linked to any theoretical foundation in nursing (Lamb 1992).
Quality of carer/user involvement	Community care (CC) in general is about tailoring services to meet needs of clients & consumer choice (DoH 1989a) and the legislation required user/carer invovlement (Hudson 1993). There is some suggestion CC made a difference in terms of maintaining people at home & satisfaction (SSI/RHA 1993b, DoH 1994), better client outcomes & lower cost in certain groups (Knapp et al 1992), improved quality of life, choice, independence (Walker et al 1995) and user appreciation (DoH 1994b). Others found little change (Richardson & Pearson 1995, Marshall 1996), delays, lack of control and neglect of less urgent (Nocon et al 1997), concern for user choice (Robertson & Wistow 1993, Henwood 1994, DoH 1994a, Richardson & Pearson 1995, Myers & McDonald 1996). Challis (1994a) noted problematic nature of measuring client satisfaction as outcome.	Nursing is moving towards evidence-based practice, value-for-money, quality assurance, practice development (DoH Nursing Division 1989, NHSME 1993, NHSE 1993, Joint Committee 1997). It supports client-centred values based on dignity, individual need, choice, consumer views, empowerment, confidentiality and continuity (DoH Nursing Division 1989, Bond et al 1991, Repper & Peacham 1991, NHSE 1993, Millard 1995, Cutliffe 1997, Joint Committee 1997).	Both positive and negative outcomes in projects were recorded. User involvement, though difficult to implement, was a feature of some, with some improvement in numbers of clients remaining at home (Knapp et al 1992), reduced hospital admissions (Askham et al 1987), evidence off more efficient/effective care for elderly than current provision (Challis et al 1990), empowerment (Meethan et al 1993) and high degree of satisfaction (Pearson undated). But findings also suggest limits to user choice (Meethan et al 1993), little difference in outcomes compared to generic care (Muijen et al 1994), including numbers remaining at home (Askham et al 1987) and little difference to satisfaction (Cullen et al 1997). Edwards (1997) concluded the promises of CM were not fulfilled .
Meeting needs	Legislation stipulated priority should be given to those whose needs are greatest (DoH 1989a), though it was unclear whether all community care client needs should be assessed, which would lead to explosion in	Targeting is less a focus of nursing literature than CM literature, though RCN (1995) suggested identification of priority groups and individuals was a function of community health care nursing. There is debate over	Failure to adopt a needs led approach resulted in unmet need in many projects, due to service/resource led practice & assessment (Peck 1992, Hudson 1993. Baldwin 1995, Robertson 1995, Lewis &

Table 3.13 Pattern-matching (1) Matching contextual variables (cont)

Issue	Data sources		
	Policy literature	Nursing literature	Case management literature
Meeting needs (cont)	public spending (Lewis & Glennerster 1996). The question of how to provide for needs of less dependent (Challis 1994a) led to advice that any disparity between assessed need and available services should be explained to clients & recorded to inform the planning process (DoH/SSI 1991b, Peck et al 1992). Interpretation of official guidance was that it sanctioned decision-making by service providers regarding who receives services (Hunter 1993a) which led to prediction of rationing through eligibility criteria (Smith 1993, Johnson 1993), compromise between needs and services falsely raising hopes (Orme & Glastonbury 1993), less dependent being overlooked (Robinson & Wistow 1993, Henwood, 1995). Henwood (1995) predicted difficulty in maintaining commitment to a needs led service in the face of rationing & resource pressures. There was also lack of guidance on how to link individual (SS focus) & population (health focus) needs (Lewis & Glennerster 1996, North 1997). But Robinson & Wistow (1993) noted improvement in needs assessment & smaller numbers in MH receiving services than envisaged in legislation was found in one project (Positive Publications 1993).	whether the main focus in nursing should be meeting needs of populations or individuals (RCN 1995, Luker 1997).	Glennerster 1996), demand outstripping supply (Richardson & Higgins 1990, Ryan et al 1993), inadequate assessment or slowness of biographical approach (Pharoah 1989, Meethan et al 1993), reluctance of practitioners to falsely raise expectations (Bland 1994) or client wishes being contrary to community ethos (Richardson & Higgins 1990). But CM was seen as beginning to meet local needs (Askham & Thompson 1990) & some ways were in evidence of addressing the care needs of less dependent eg through Age Concern (King 1990), other services (Lear et al 1993, Chambers 1986), informing future allocation of resources (Thornicroft et al 1993).

Table 3.14 Pattern-matching (2)

Propositions
1. Professional issues (A) There is similarity of principles and processes between the disciplines of case management and community nursing. (B) The main community nursing specialisms are suitable case managers, especially CPNs and DNs, with HVs and LD nurses less well documented. (C) However, there is a danger of professional role erosion, deskilling and uncertainty for community nurses in the case management role, due to the new managerial culture and social services having lead agency status. 2. Organizational issues (Ai) The organization of case management, which should be planned strategically, integrating all levels vertically (national, local, individual) and horizontal (cross agency), is problematical. (Aii) Planning and implementation should similarly involve all levels of nursing staff affected, but is not a reality. (B) The effects of change are often a cause of anxiety. (C) Good interagency collaboration, which is essential to case management, is difficult to achieve in practice, especially at the service delivery level, due to cultural, structural and personality differences. 3. Preparation and support (A) Locally organized training for case management, involving all levels of staff and preferably on a joint agency basis, is not currently adequate. (B) Local mechanisms for clinical supervision, involving support from experienced practitioners within the same discipline and necessary for good practice is also lacking. (C) Accountability in nurse case management is likely to extend beyond traditional lines, to include interagency elements and this presents problems. 4. Case management model The predominant social service model is adopted by many nurses, though the policy recommendation to separate purchasing and provision may not be the best model for community nurse case managers. (Ai) The major responsibility is for purchasing, including financial assessment. (Aii) There is usually some budgetary devolution, though not necessarily to case manager level, which may be difficult to operationalize, (Aiii) with variable amounts of provision where appropriate. (B) However, community nurses encounter difficulties acquiring equal recognition in the case manager role. (C) A separate advocacy system involves less conflict. 5. Practice conflicts (A) Resources (time, money, services) are likely to be inadequate for realizing the ideals of client involvement and satisfaction, quality care and a needs-led service. (B) High caseload numbers and increased pressure of work are also likely to be a potentially compromising feature. (C) There is some evidence of strategies to minimalize this, such as targeting, addressing the needs of less dependent clients or feeding data on unmet individual needs into general service planning.

3.4.1 Pattern-matching (3) case 1

Proposition	Source	Evidence from data
1 Professional issues	M001 N002	"It's not necessarily whether you're a nurse or a social worker or non-clinical, it's to do with personality and that's a very difficult thing to quantify...the right person for the job". "I think I'm probably showing that nurses are capable of it [CM] and can do a good job". "The two [CN and CM] are so enmeshed". But maybe difficult to identify social needs without SW qualification, though "it doesn't seem as if anything is being missed". Finds that being a DN means she can liaise with primary health care team and DNs and be accepted. DNs "capable of acquiring the expertise...but I don't see a major role for all DNs doing their own care management for all their clients" as they are experts in their own field. "It's important for me as a nurse to keep up in my clinical skills...I don't want to become all social services because that loses all the difference of it being a health worker accessing SS". "The reason why this sort of job has not been done before is because of jealously guarded professional backgrounds". They should remain in tact but at the same time there can be overlap".
2 Organizational issues	M001 N002	"The government seem to be splitting two ways; they seem to be saying that everything should come from primary care...and they are at the same time giving a lot of things to SS". Some of ideas for nursing put forward to commission. "Not a lot has changed ... it's been done piecemeal, the same as it was before...that makes sense". "Now we have close links with SS" though "the interface between SS and health is sometimes a bit difficult". Effectiveness of team work depends on personalities: "it's vital they get the right sort of person in personality wise - someone who is sensitive to all the different agencies". Good liaison with doctors who appreciate having a "named person". "Amongst all this change" main purpose "fundamentally hasn't changed". "Things are possible". Relationships between SS and nursing not good in the past as previous DN CM had attitude problems - "there were a lot of barriers to be broken down...they were very defensive..they didn't like us at all". Due in part to having to call in SW CMs to do the financial assessment - "the dirty work". Since doing the full assessment, relations better - "there's no barrier...I'm treated as a member of the team".
3 Preparation and support	N002	"I've been enabled to go to a lot of training days with SS. They pay for all those. I met various people and I think that's very important". SS have been "very supportive" largely due to the personalities of team manager, CM and herself - "personalities are very imortant". "Difficult to answer" who accountable to. "I just act as if I have two bosses...I can't see that as being a problem at the moment". Being accountable to someone from a different discipline "doesn't worry me because I'm not acting as a nurse when I'm working with that discipline".

3.4.1 Pattern-matching (3) case 1 (cont)

Proposition	Source	Evidence from data
4 Case management model	M001	"The problems I have identified with SS have been the attitude, the protectiveness of SS feeling threatened by a nurse". I think DNs should be able to do the initial assessment".
	N002	CM is "to be able to go in and assess quite a wide range of needs and be able to do something about it". Advantages in accessing budget in provision of quicker service. Not involved in care delivery - "I just advise the nurses". "What I ask for I get. It's very satisfying and I feel I'm a purchaser and I'm purchasing a service to fulfill a need". Would be able to act as client advocate but "I wouldn't be totally impartial because I would be an interested party". DNs suitable advocates as they know the client. Some differences between nursing and SW CM. Same financial assessment form as SS and care plans. "I think DNs are half way to being quite skilled social assessors...but I also have the advantage of having skills of health assessment".
	Doc	SS community care documentation used by all agencies.
5 Practice conflicts	M001	"We've had to put in resources we can't afford, and, of course, nobody's budgeting for this". "It takes 3-4 hours to go through the paperwork". "Our level of work has increased obviously". "There is a lot of chopping and changing. They [fieldstaff] feel that there are people who should have been case managed who weren't"."Our staff are often saying that they [clients] need more than they've been assessed for. Carers are doing more and more and not getting the support they need".
	N002	"It's obviously not a bottomless pit but at the moment there seems to be enough money in the SS budget to meet the needs of the clients that have asked for it so far". "DNs...have quite enough to do and care management is very time consuming...I really don't think they have the time..to do it". "The client should be given a care plan". "I find it quite rewarding ... rather than going into someone and saying 'these are the resources we have, how can we best fit you into them?', now you go in quite open mindedly and say 'let's look at what you need and then lets fit what we have to you need' ...it's the other way round...it's very much service user choice". So far able to meet all clients' needs "not always their wants, but their needs" though "it's a matter of compromise". Noted fewer people going into homes and more enabled to remain in community.

Pattern-matching (4) case 1

1. Professional issues

While the manager felt personality to be more important than professional qualifications for the CM role (+), the CN saw that, though differences existed between CM and CN, these could be overcome to unite the two roles (±). There was agreement that DNs can acquire the expertise for CM (✓) while retaining their own specialist skills but the CN was aware of the potential for losing professional identity within the dominant SS culture (✓).

2. Organizational issues

There was a feeling expressed of lack of clarity and integration in current organization (✓). The manager obviously had some involvement in CM planning though the CN's remit appeared limited to liaison work (±). For both respondents, the change process had been minimalized, and they remained positive about it (x). They also agreed that interagency teamwork could be, and had been, problematical, and felt the crucial issue to be the personalities of individuals at both practitioner and management level (✓).

3. Preparation and support

The CN expressed satisfaction with local interagency training for CM (x) and was happy for the team leader to adopt the support role in cross-discipline supervision, as personalities gelled (x). The CN was also aware of cross-agency accountability, but appeared to be able to separate the lines of accountability satisfactorily (x).

4. Case management model

The CN was clear about, and happy with, the purchaser role (✓), with access to a budget (✓), but was no longer involved in the provider side (x). Though both respondents felt CNs were capable of adopting the same model, with an expertise in health assessment, the manager agreed that SW CMs had difficulties accepting a nurse CM (✓). Though advocacy was thought to be compatible with nursing, the CN agreed that conflict could arise from combining CM and advocacy roles (✓).

5. Practice conflicts

Although the manager appeared to feel more acutely the lack of finances and time than the CN, there was clear awareness of the issue (✓). Both respondents agreed that combining CN and CM increased workload considerably (✓) and the manager noted the adverse effects of change these factors had on user-centred services. Though the manager focused on the inability to meet needs, the CN remained optimistic, so long as CMs were guided by needs rather than resources, were able to differentiate needs and wants and to negotiate with clients (±).

3.4.2 Pattern-matching (3) case 2

Proposition	Source	Evidence from data
1. Professional issues	M011	"I felt that there were some very good "F" grades who could act as assessors and perhaps even care managers". "There are certain [nursing] models that actually are better at taking on an assessment process than in the care management" which "does drag you away from that [therapy]". "Coming from a learning disability background, it's something we have always done with our clients". "Care management" would "actually take you away from your specialism". But CM for nurses can actually be "a professional progression" if there is training.
	N012	"I like the therapeutic part of the role, like CPA. I would be quite happy not to be a care manager." "Nurses are very used to doing assessments". "Personally I am very confused...I think it [CM] belittles and it doesn't leave enough time for the therapeutic role". "It's the uncertainty that surrounds it that's difficult".
	C014	"D [CM] came along and she is a sort of a social worker isn't she?".
	Doc	Referral, assessment, care plan, review & monitoring forms all SS designed and appear to differentiate care manager, social care manager and keyworker, though no discipline mentioned.
2. Organizational issues	M011	Current organization of health & social care "gets a bit fudged...it's not clear". "Challenging behaviour is open to interpretation". Agreements were made at senior level although "the financial negotiations were left to me". "The health people...never attended any of the workshops and stuff". "The feeling was that the care management ... people had to take it on no matter what". There is a feeling of insecurity. "It would have been nice to take the process more slowly". "There has always been a lot of good working relationships, particularly at this level". But "CM is a SS thing and no matter how hard we try to joint work..there is still an element of them and us".
	N012	"I am not against change...but...I think it is very much a management decision really as to what exactly is required...but I am not included" and "haven't got a clue what my future is". "Quite a lot of difficulties between SS management, health management". Interagency referral system good, but interagency difficulties at practice level due to lack of coterminosity with SS. However, "we have actually...set up a liaison meeting with our colleagues from [named] SS".
	C014	"She [psychologist] liaises with D [CM]. They're all based at Wilton Road, you know the teamwork".
3. Preparation and support	M011	"We had courses leading up to it telling us about the assessment process". "There is some talk of almost a year's training and probably recordable to make nurses and SWs accredited CMs. They actually have to show competency that they are able to do this".
	N012	"The move generally in training is to train together... and we've done a whole series of community care training here run by SS and we have been involved and that's been great". But felt that such training may produce a generic practitioner and specialist support would be lacking.

3.4.2 Pattern-matching (3) case 2 (cont)

Proposition	Source	Evidence from data
4. Case management model	M011	Although traditionally nurses have not been involved in costing side of care, this is "everybody's work" now. Care delivery also important: "I would hate to see my CMs becoming commissioners". The two aspects should complement each other. Nurses feel...that they are being drawn away from the real nursing work". Happy for nurses to do financial assessment as SWs do, though SWs "do a different aspect, they go a bit further". Nurses more prepared for LD work than SWs.
	N012	"Mostly the CM side of my role seems to be doing the SS assessment ... social care ... and to access money to purchase slightly different services". "I care manage and do therapeutic work and that's very difficult...to separate the two". Case management "has slowed up the care...personally, I would have preferred to have done the clinical bit straight away". Criteria for referral "has never been discussed and never been agreed". Assessment form devised, and shared, with SS.
	C014	"D gave me a lot of moral support ... and you just know she is there and she is on your side"."Any little problems and you know she will help me sort them out ... she keeps pressing that we do need this".
5. Practice conflicts	M011	"I think that it is very time consuming". Not resourced to take on all referrals and care manage and "I think that it does actually deviate from the real work of the nurses". "If they require a specialist service then it should be available to them". "I wanted to work with this particular client group and if the CM process takes me away from that...I would have to throw the CM out".
	N012	"We haven't got enough health resources". "We haven't got enough workers ... hence my [CN] waiting list". Caseload quite small "but it is time consuming when you only work 30 hours a week". "I'd have to open a bottle of wine if I close a client ...so it's going to build up". Care not always user-focused. There is a "big gap for people who have a learning disability who are not getting a nursing service from an RNMH". But "I don't think this team has anybody waiting for care management" and currently all clients' needs met.
	C014	Involved in care decisions, though there "wasn't much choice" in daughter's latest move. But CN has been "very, very helpful ...I can talk to her about any problems ... a lot more helpful than some of the staff ... I feel very positive about it". Previously felt "left in the middle of nowhere" as problems just got passed on. Recently "the whole situation has eased". Previously few staff trained in LD, which affected quality of care.

Pattern-matching (4) case 2

1. Professional issues

There was more enthusiasm from the manager than from the CN for the suitability of LD nurses for the CM role (±). Though both saw CM-type assessment as being traditionally part of the nursing remit (✓), they agreed the role may detract from care delivery and may lead to undervaluing of professional skills. The CN also commented on the uncertainty of her situation (✓).

2. Organizational issues

Organizationally, health and social (including LD) care arrangements were felt to lack clarity (✓) and, although the manager, with other health personnel, had been involved in negotiations, the lack of involvement of health staff at practice level (±) and the speed of change left a feeling of insecurity (✓). This had affected the quality of interagency relationships among practitioners, though it was unnoticed by the carer (✓).

3. Preparation and support

Both manager and CN felt joint training for CM had been good, with the manager talking of future plans to extend this to a competency-based recordable qualification (x). The CN had reservations that, with multi-professional preparation, the specialist nature of nursing may lose out to genericism (+). There were no data recorded on supervision (-) and accountability (-).

4. Case management model

The manager appeared to agree that a purchasing element was appropriate to CN CM, though the CN felt more strongly that clinical and specialist work was being jeopardized with this model (±) so long as this did not undermine the care delivery function, also noted by the carer (✓). The carer further emphasized the importance of advocacy within the perceived model where care delivery is a major feature (x). There was no mention of budget holding (-) or difficulties of recognition (-)

5. Practice conflicts

There was strong agreement that a lack of resources and heavy workload could compromise quality of care (✓). The CN also raised the issues of expanding caseloads, with few discharges, and a loss of user-focus as time passed (✓). However, both professionals felt that CM could actually meet clients' needs so long as there existed a referral protocol which allocated to nurses those clients with predominantly (LD) nursing needs and specialist (LD) services were available, and the carer's comments supported this (✓).

3.4.3 Pattern-matching (3) case 3

Proposition	Source	Evidence from data
1 Professional issues	M021	CM aspect of job "always there" apart from paperwork & financial assessment. However "always felt we [LD] would eventually be handing over" to SS as lead agency. Community teams have "lost their status now". They feel "threatened".
	N022	"Always seen it as part of my existing job...we used to call it keyworking". In LD "we've always done needs assessment" including financial and social assessment. But now more paperwork & purchasing. LD "out on the sidelines".
	N025	"Just an extension of what I was already doing" now formalized, including assessment for social & financial needs. But "a lot of things in CM aren't appropriate to my role" eg contracts for service provision, paperwork. "I personally prefer to spend more time being with clients". Part of time acted as CN and found this "pretty confusing". "We've got recognized areas of specialism". Assessment forms "don't cover areas important for people with LD" ie learning, work, leisure.
	N028	Felt CNs naturally took on the keyworker role. "Happy to assess financial needs". But more paperwork and some aspects new eg benefits, housing". People were "floundering in the past...but more clear cut now". Reservations about job security, as there were certain benefits of staying in health. Given information after decisions made which was "quite unsettling...doesn't do morale any good".
	Doc	Local LD leaflet on CM stated: "CM is a function of somebody's job. In the [named] SS district, LD services are care managed by social workers and community nurses.
2 Organizational issues	M021	Community teams have traditionally "done their own thing". Difficulties in liaison with SS within current structure. Team had been involved in the "massive ongoing developments in the local community. CNs "feel they've been railroaded into it". Since April, long history of good working relationships damaged as result of emphasis on CM. SS negotiated with health purchasers without discussion with LD board. Had "no personal conflict".
	N022	Structure more geared to CM than to LD. This was "a big worry because none of us really know where we stand in the system or what the future will be". Not a geat deal of change since April '93. But it was "another exercise for the sake of change".
	N025	Some confusion around relationships with speech and physiotherapy, outside team. Some SS contact though" I accept that I don't know a lot about their job and they don't know a lot about mine".
	N028	Some involvement in decisions and discussions about finances that have been handed over to SS, but not aware of dates of meetings or timetables. When CM came in "most requirements in this area took on a natural progression". However it was unsettling and not helpful to clients ". The 2 lead agencies (health & SS) were working adequately for provision for people with LD, though it had not always been so.
	C024	"He's been doing the same for us practically since we've known him".

3.4.3 Pattern-matching (3) case 3 (cont)

Proposition	Source	Evidence from data
3. Preparation and support	M021	CM coming in involved "a lot of training ... and direct input from SS". CNs had "quite a bit of support". SS "seem to have got their act together" with plans to develop it. "They will see themselves as having two bosses now".
	N022	"Quite a lot of training" though "a bit of a rush...at the last minute". Felt a lack of support. "The team manager hasn't a background in LD...I don't feel he fully understands". Difficulty because "you're having two bosses" - could be improved by closer links between service director and team manager.
	N025	Felt inadequately prepared. Learned on the job for 4-5 months. Training programme introduced just before April and "not well planned". No supervison from service director as "he says he doesn't feel able to supervise us as CNs because he doesn't know anything about community nursing". Split accountability (to SS team leader and nursing director) "not a problem".
	N028	In service training on admin. "adequate but not spectacular". Mostly learned through experience of CN.
4. Case management model	M021	Problems with purchaser/provider division at macro (trust/HA) level. "Theoretically, CMs will be purchasing". Responsibility for budget would mean more control over purchasing. CNs tended to get referrals where health needs predominate. Counselling done by both.
	N022	CM about "assessing and purchasing the social care that people require". CNs are involved in provider work. Devolving budget could improve consumer choice. Clients with "a lot of health needs" tended to go to CN, but "not any real distinction".
	N025	CM "an extension of what I was doing. Combining purchasing and provision leads to conflict. "I'm very confused...technically I should have to order services from myself". "Strictly speaking you can't be an advocate for them [clients] as well as being their CM" because of purchaser role. Felt much time was wasted doing things SS should do.
	N028	CM is "naturally taking over the role of keyworker - the central person for information". Reduction in provider work. Hoped to retain some "hands on" role. Individual budget might improve client care. CM as possible citizens' advocate but conflict if paid for the role.
	Doc	Officially CMs have both purchaser and provider functions. LD leaflet on CM noted no difference between SW and CN CM.

3.4.3 Pattern-matching (3) case 3 (cont)

Proposition	Source	Evidence from data
5. Practice conflicts	M021	Lack of time & money would affect ability to meet needs. Workload had increased due to referral system. Need for more staff.
	N022	Extra workload in addition to what already doing with no new staff. Need to reduce caseload. More time for specific LD work & more client choice. But working to "rigid paperwork system" & it has "taken away from the work that CNs have done". Noted unmet social needs. These logged by SS and being considered in budget for coming year. "I find [the role] unsatisfactory to a degree".
	C024	"It's a question of finances all the time". "We've had one or two times when we've had to complain".
	N025	"No time to go into the financial side". Lack of new services. "I'd prefer to have a lot more flexibility" to meet individual needs. Felt overworked. Need for smaller caseload. Advantages in being CM but also "very confusing." Felt like "messing around doing things when I could be with client". Family confused about CM role. If need identified but no money or no service available this was recorded centrally as "statement of unmet need".
	N028	CM has cut down on number of people involved in meeting client need. Also "quality of service provision has declined a little". "I think we can meet the basis, but not 100% of what clients need". Has job satisfaction "as long as I've got a certain amount of 'hands on' work".
	Doc	"Shortfalls in service will be identified so that the statutory services, the private and voluntary sectors, are aware of future service needs".

Pattern-matching (4) case 3

1. Professional issues

All respondents agreed that CM was a natural role extension for community LD nurses (✓), though one CN felt some funtions of CM (eg paperwork) were not appropriate to the nursing role and reduced time with clients (±). There was also agreement that the specialism had been marginalized and disadvantaged in the planning process and there had been loss of professional status and security for community LD nurses as the balance of power shifted to SS (✓).

2. Organizational issues

There were obviously some organizational problems in the past resulting in uncertainty and isolation for LD workers, though respondents' emphases differed in response to this issue (±). There was some discrepancy between the manager's view of CM involvement with other professionals and wider organizational development, and the CMs themselves, who felt some confusion and lack of involvement (±). There was also dissonance between the manager's interpretation of CM implementation being forced through, and the CNs and carer, who had experienced minimal change in practice, unsettling though even this was (±). There was evidence from all respondents of damaged interagency relations since the inception of CM, though this appeared more marked at management than individual levels and largely due to misunderstanding and poor communication (✓).

3. Preparation and support

Although there was training for community nurse case management, to the CMs themselves it appeared barely adequate and informal, supporting the need for better organized preparation (✓). There were mixed feelings about the adequacy of supervision, the manager expressing greater satisfaction than the practitioners, who seemed to feel more acutely the need for support from their own discipline (✓). There was agreement within the case that accountability was a complex issue and would require good interagency relations and understanding where team leaders were from a different discipline (✓).

4. Case management model

Although the manager saw the CM role to be theoretically on the purchasing side and one CN saw provider work as decreasing (✓), the other two CNs saw the current emphasis on provision as important and likely to continue (✓). Two respondents agreed that a devolved budget would be advantageous but this may be a problem in view of lack of time in practice (✓). But there was no evidence of problems with recognition from SS (x). Although advocacy has been seen as a nursing responsibility in the past, the purchaser/provider division has highlighted the potential conflict where nurses combine both dimensions in their practice (✓)

5. Practice conflicts

There was marked agreement among respondents with the proposition about lack of money, time & services and the effect this had on meeting need despite the fact that CM had improved certain aspects of care(✓). There seemed no doubt among respondents that assuming a case management role resulted in workload pressures, due to inadequate staff levels as well as referral systems (✓). There was some willingness to change practice towards greater flexibility and realism to cope with this and nurses tended to be allocated clients with predominantly health needs, though this was not formalized, leading to some inappropriate "social work" being undertaken. All three CNs, as well as local documentation, were concerned about identifying unmet needs and the issue of feeding this information into service planning (✓).

3.4.4 Pattern-matching (3) case 4

Proposition	Source	Evidence from data
1 Professional issues	M041	"The G grades ... effectively end up being the care manager because the've got the knowledge" and "excellent assessment skills". "We've been doing [CM] for quite a long time and we want to move on"."Some of the nurses want formalized that they are the key worker because that's causing them a great deal of frustration". "I think DNs have been undervalued".
	N042	"I think DN is going to be called into that sort of arena".
	N045	"To me it doesn't feel normal to do what I'm doing".
	N051	Some fear for home care teams taking over nursing role: "if we don't fight our corner our role will be bypassed".
2 Organizational issues	M041	"We did a lot of joint planning ... with being a whole district trust it seemed easier to work ... we're not separate acute and community trusts". But "politically within SS there's been a kind of resistance". "It's hard to work in partnership because they're a different organization, different philosophies ... that's partly ... personalities". Talked of "confusion of who's doing what".
	N042	"We liaise quite a lot" with SS and devised assessment form jointly but "it can get very territorial: 'they're my records, the nursing records'".
	C043	"At the moment the SS are funded by local rates and the nurses are health service. The sister can request but she doesn't have the power over them. That would be ideal".
	N045	"It (SSD) is separate in a sense but I think we do dovetail ... they're not just a voice on the end of the phone". However had "one or two [relationship] problems just this past year" with CM. Involved in discussing assessment format with SSD. Unsure of role of care managers in SSD.
	C046/7/8	"At the beginning we had 3 or 4 different people came from - I don't know what it was, just the nursing service, I don't understand".
	N051	"We have got a really brilliant relationship with most of the home care teams in [town]". Regular meetings with SSD. Nurses instrumental in changing assessment forms though locality manager gained recognition for nurses to do assessment. However, problems existed with some home care teams: "they view you suspiciously ... I think it comes down to personalities". Unsure of who are SS CMs. Changes were taking place prior to CC.

3.4.4 Pattern-matching (3) case 4 (cont)

Proposition	Source	Evidence from data
3 Preparation & support	M041	Plans for joint training and have both had training and provided it, with expectations that new DNs will receive more training.
	N042	No specific training for keyworker role: "I would say my DN training is my foundation for that". But "I think the managerial support I receive is of paramount importance to me". Accountability "to myself and to the UKCC, but I'm accountable to the individuals, to my patients .. and also to my employer, my nurse manager". But not acountable to SW manager in legal sense.
	N045	Training consisted of DN and CPT course and familiarity with nursing process.
	N051	"No specific training ... none other than your DN training" and from being a CPT. Support good: "I think we're lucky in the locality manager that we've got".
4 Case management model	M041	Saw nursing as provider role. Involved with coordinating/advocacy part of CM. There is an issue "around an acceptance that DNs will take the lead role for certain things that are more health". Has no problems with idea of CNs holding a budget.
	N042	"Being the district nurse case holder, then I see myself as the keyworker". Takes responsibility for clients where "a high percentage of the care is nursing care intervention". Also "I think it's important to actually deliver that care". Noted a conflict where assessors are also care givers, though felt could "step back from the care I'm delivering and look at it critically". Felt role included advocacy. Also "the financial side of it, as DNs we get involved in that", though "I've no training in meeting the needs of a budget". Manager involves DNs in budgetary decisions.
	C043	Felt SW would be the person she would approach with problems etc., though DN is "a good friend .. she's supportive, I feel secure".
	N045	Role as team leader and keyworker to all on caseload. Unhappy about reduced patient contact. "I've found it very difficult to let go of patients". Not responsible for budget but "I don't think I'd mind particularly ... we got a breakdown of how much we were spending". "I feel I'm an advocate to see they get the right treatment".
	N051	Keyworker role where there are specific nursing needs. CMs from SS may also be involved but "to be honest, I don't really know what they do". Looking towards joint assessment forms with SW. Not responsible for budget "but we're very budget conscious". Not keen on devolution as "I don't want my judgement guided by how much money I've got". Sees self as client advocate.
	C052/53	Described SW as arranging most things though when asked who has overall responsibility mentioned nurses.
	Doc	Form for nursing need assessment when responding to request from SS outlines nursing assessment areas.

3.4.4 Pattern-matching (3) case 4 (cont)

Proposition	Source	Evidence from data
5 Practice conflicts	M041	Noted shortage of cash recently. About CM "the reality is that it's obviously resource-led whether we like it or not". Also workload increased as DNs have "not been good at saying 'no'". Quoted instances in recent past of poor services over Christmas. Problems in meeting needs ."I think the complex care patients are getting what they need. What's dropping off the end from SS point of view are the in-between ones".
	N042	"I think it's resources, I think it's finances, I think it's politics and I think - dare I even say it - it comes down to personalities of clients and patients. But it's the real world. It happens". Also carers are important - "it should be manadatory that they are involved". Not always able to meet needs "but ... I'd like to think that 90% of the time I do meet needs within my resources ... but if we recognize a need that we can't meet then I have a responsibility to document that and give to my nurse manager so that she can make a decision '. "Whereas our DN service was resource-led it's now very much needs led".
	C043	Involved in deciding about services "to a certain extent" but "I don't consider it satisfactory". Especially "I'm not on the best of terms with SS".
	N045	Difficult to get work done with travel, paperwork and meetings taking up so much time.
	N051	Involves patient and family in assessment and care plan. Budget holding may affect quality of care.
	C052/3	Not involved in deciding care: "it was all done through a social worker in the first place". However not keen to have been more involved as "she was a good SW".

Pattern-matching (4) case 4

1. Professional issues

The opinion was expressed that G grade CNs make good CMs/ keyworkers, having the knowledge and assessment skills (✓) and, though the CNs saw DN work as moving in that direction, one DN at least was obviously not too comfortable with the role (±). The manager highlighted the frustration caused by DNs not having formal recognition of the role and one DN saw a danger of losing professional (nursing) status to encroaching home care teams (✓).

2. Organizational issues

The manager described good integration in the planning and implementation of CM (x) with nursing involvement at management level (x). Change appeared to be gradual and predated the community care initiatives (x). All three DNs described good interagency relations at practice level. However, "territorial" problems had occurred between health and social care agencies according to all respondents, including clients/carers, due to "politics", different philosophies, lack of familiarity and personalities. This led to confusion for both professionals and service users (✓).

3. Preparation and support

There was a difference in perception of training for CM between the manager, who felt the preparation had been significant, and the CNs, who relied on DN and CPT training (±). Two CNs expressed satisfaction with the support received from the locality manager (x). Lines of accountability appeared clear to the CN who mentioned the concept, and there was no mention of problems (x).

4. Case management model

The keyworker model appeared to give little priority to purchasing (x) but involved a substantial emphasis on provision (✓), which was considered important. There was no budgetary devolution as such (x) and this was seen as potentially problematical, though practitioners were appraised of the financial implications of their work. There appeared to be some problems, even with this model,

over CNs assuming a lead role (✓). All three CNs (and to some extrent clients/carers) saw themselves as client advocates, which may be more workable with this model (x).

5. Practice conflicts

There was general agreement that lack of resources (✓) and workload (✓) were affecting quality of care, though this was not stated strongly. One client and one carer did not feel involved in decision-making but, significantly, the carer did not wish for any greater say. The manager felt choice and opportunity for very dependent clients was better than prior to community care and one CN felt that on the few occasions where needs were not met then this would be fed into future planning (✓).

3.4.5 Pattern-matching (3) case 5

Proposition	Source	Evidence from data
1 Professional issues	M061	"Nursing's been very different [to SWs who are the CMs]". "CPNs have always developed a system through IPC". "GP fundholders wanting to purchase private counselling services...is obviously a threat to our services"."The process was pretty badly handled but the philosophy behind it was right".
	N062	Described role of CPN as care-coordinator under CPA. Much role confusion with early project ironed out with relaunch. Role appropriate to E grade nurses.
		"It's quite difficult to work out what's the difference between care coordinator and care manager".
	N065	Described role of CPN as care coordinator. Unsure of future role.
	N068	In future, role as care coordinator will be seen as main area rather than professional designation as CPN etc. Did not feel on an equal basis with SW.
	Doc	Local CPA policy stated "a care coordinator is a professional working within the community, who may be a CPN ...". No mention of case management in documentation.
2 Organizational issues	M061	Talked of "one management structure" - ie acute and continuing care. Involved in setting up criteria for pilot but, though philosophy of CPA good, "I think it's been introduced in a cackhanded way ... and there are lots of different messages coming out of the DoH" and "perhaps it should have had a longer timescale for introduction". Future change likely. Project developed with SS. There can be cross-fertilization there". But also difficulties: "getting everybody to work the same ... with consistency".
	N062	Talked of "a lot of confusion ... little coordination across the four sectors". Not involved in working party producing assessment forms. Difficulties liaising with keyworkers leading to duplication. But now felt "more aware of [other] agencies" though "sometimes you get a little bit of 'it's my territory, it's my property, hands off'".
	N065	Felt new practice "tends to have unfurled itself in a haphazard fashion". Not involved in devising assessment form or discussions "until the last minute". Liaison with GPs and consultants not good. Some SS CMs but "it's quite difficult to work out what's the difference between care coordinator and care manager". But also thought SWs were accessible and reviews held together.
	N068	New policy "working in the way we've always worked". But "things are changing all the time". Not involved in development of assessment form but would like to have been. CPA "a great concept" and "it really highlighted the fact that lots of us were doing the same thing". Now far more discussion and working together. However, "it's very difficult ... SS and us have a different management structure" leading to some conflict in working.
	C069	Client did not notice any difference in ways care coordinator worked over time.

3.4.5 Pattern-matching (3) case 5 (cont)

Proposition	Source	Evidence from data
3 Preparation and support	M061	"I went on numerous conferences before it started and everybody's doing it differently. I think the guidance for it was poor". "The training was left to ourselves basically to do it in-house ... so it wasn't very good". Need more resources for training.
	N062	Training consisted of meetings and training in welfare benefits, which was sufficient but general training not. Managers supportive. Supervision monthly plus meetings with colleagues. Accountable to hospital manager with nursing background.
	N065	Training non-specific and unstructured, apart from benefits training, which was good. Would have liked more preparation. Felt adequately supported: "there's always someone around". Accountable to hospital managers and care group coordinator but "I don't have a line management thing".
	N068	Training on benefits "but time was limited. We could have done with more training". Felt adequately supported in role "until leaving regular supervision. There's always someone there on the end of the 'phone" and team supportive. Accountable to nurse managers.
4 Case management model	M061	"Care management is ... more of a purchasing role. The CPA is about a worker directly involved with a person". But "people were just getting mixed up with the terminology". "Certainly in [place] we don't have budgets to purchase care". Care coordinators "have to be clinically involved as well ... it's a better use of resources". "I would have felt that clinicians wanted ... 'hands on' input".
	N062	"The care coordinator is supposed to be the care manager". SS take on role when physical need in greater. Important to assess for financial needs. Would be useful to have " a little fund set aside to use at our discretion", or even control budget. But did not think this would happen. Not sure if SW CCs/CMs have budget. Involved in care delivery. Felt able to take on advocacy role as "the client trusts us" though some prefer to use advocacy service.
	N065	There are care managers in SS but difficult to work out difference between CM and care coordinator. Appropriate to assess for financial need but had no budget, though would like" a small budget. A bigger budget "a bit daunting". Involved in care delivery - "just an extension of what we've always done anyway". Able to act as client advocate.
	N068	"It would be great to have some sort of budget". But "what would happen if all the money's spent?". Not much contact with care managers: "I don't think the roles are that much different". CPA coordinator "doesn't necessarily have to deliver the clinical care", but found it difficult "just stepping back and not being involved". Able to be client advocate.

3.4.5 Pattern-matching (3) case 5 (cont)

Proposition	Source	Evidence from data
5 Practice conflicts	M061	Noted lack of provision: "It's OK having the budget, but...you haven't got the right services to purchase". But most packages of care are fulfilled. In future "we're going to to have to concentrate more on people with real mental health problems".
	N062	Now have criteria for care programme. But if there is pressure on beds, may be inappropriate discharges and referrals, though generally able to meet needs as perceived by client. If not, unmet needs documented. Tendency toward pressure of work (including paperwork, meetings and admin.) from ever-increasing caseload plus monitoring system duplication, with few discharges, though introduction of skillmix has helped. Need for extra resources "because there is only so much you can do to make the policy work". Expressed dissatisfaction to HQ and in supervision.
	N065	Noted shortage of services. Criteria for CM. Takes on all eligible though numbers high. Finding the resources is difficult in rural area. Further problem with short-term nature of pilot, so needs left unmet when service ends. Involves service users, carers/friends in assessment. Strategies employed such as use of charities & voluntary organizations. Unmet needs recorded, but nothing else happened with data. Feels job is satisfying.
	N068	Pilot identified criteria for CM. Noted large numbers: "I'd like more time to spend on those people". But "basically we don't turn down referrals" if necessary "we would either operate a waiting list system or look at who's got the greatest needs". Found it difficult not to give priority to CPA people and "others tended to get neglected". With budget it would be "very difficult to say 'no' - what would happen if the money's all spent?". Document unmet needs "but no-one's picked it up so far". Involves client in identification of needs, though "there could be a conflict of interest, for instance if a client says 'I don't need medication'". Getting job satisfaction.

Pattern-matching (4) case 5

1. Professional isues

The manager felt issues which separated SW CM principles and nursing principles could be overcome (✓). There was a general feeling that CPNs had always pursued a care-coordinator type role, though one CN felt it to be a professional designation in its own right (±). There was also a feeling of uncertainty and one CN was not sure of the difference between CM and care coordinator roles (✓).

2. Organizational issues

While the manager talked of an integrated management structure, the CNs gave an impression of lack of coordination in the changes (±). Although the manager had some involvement in setting up the pilot, implementation appeared disorganized, a feeling echoed by CNs, who felt left out (±). The speed of change led to general feelings of uncertainty (✓) and, although multi-agency working was perceived as advantageous, and had improved, there remained practical difficulties in making this a reality (✓).

3. Preparation and support

Despite attending conferences, the manager felt that different interpretations of case management remained, and that training for CNs was not resourced or supported. The CNs agreed with this view of inadequate preparation, apart from training on benefits (✓). All the CNs felt adequately supported, especially while in supervision (x). Accountability lines appeared clear and no problems were mentioned (x).

4. Case management model

There was marked disparity and confusion displayed by respondents over terminology and role interpretation here. The manager talked about care coordinators under CPA having a (generally desirable) clinical role, while the separate role of CM, adopted by SWs, was primarily a purchasing function. All three CNs were, however, unclear about differences (if any) between the two roles and were unsure how SWs functioned (±). The CNs either emphasized care delivery, or the difficulties of not being involved in care (✓). There

was no dedicated budget and, although all CNs talked of the benefits of having a small, discretionary fund, complete budgetary devolution was felt to be inappropriate (✓). There were mixed feelings on whether nurses were accepted as assessors (±), but all CNs felt able to be client advocates, as relationships were based on trust (x).

5. Practice conflicts

There was unanimous expression of lack of suitable services and funding "to make the policy work" in a rural area (✓). Also, there were high caseload numbers, with few discharges, pressure of work and there were felt to be unmet needs left when the pilot terminated (✓). But many strategies were in evidence, which one CN felt led to improved outcomes, such as targeting, documenting unmet needs, skillmix, expressing dissatisfaction to managers, use of charities and voluntary organizations, operating a waiting list and making suggestions for new services (✓). However, targeting often meant the less needy were neglected and there were further difficulties where the concept of user choice conflicted with professionally assessed need.

3.4.6 Pattern-matching (3) case 6

Proposition	Source	Evidence from data
1 Professional issues	M081	"It was felt that the person who knew the client best should be the care manager". Felt G grades can assimilate CM role though not with budgets. CM very similar to CPA. One of CPNs focusing on people hearing voices as specialism. But described mental health team as one of smallest in area and "unfortunately what tends to happen is they get swamped".
	N082	CM "something that we've always done, particularly when we've been working long-term with clients". CN CM in area used primarily for residential & nursing home placement assessment. "Where a nurse is care manager they can obviously see the process through from start to finish". "The case should be allocated to the worker with the most suitable skills". Did not think users/carers noticed change in CPN role after assuming CM. But "it may be that it will be decided that being a CM isn't an effective use of our time".
	Doc	Specialist assessment documentation for CM includes CPNs.
2 Organizational issues	M081	Felt unhappy about organizational focus of CM on respite and residential accommodation. Manager had some influence through sub-group and mentioned financial decision-making power of G grade CMs. Everyone involved in devising assessment: "a bottom-up aproach". Nurses now "in the decision-making arena". Described current change as "an evolution", though there had been resistance 12 months ago. "Everything's in turmoil at the moment". Described "power struggles going on with consultants, CPNs CMs and keyworkers". But "SS and health have worked really hard with the care management ... at ground level there was always a good bit of work going on together but when you got into planning and management levels it was just real battles and I think that's changed".
	N082	Was part of subgroup recently updating assessment forms. Felt effects of change: "you're being pulled in different directions by so many changes". Did not find CM lent itself to multidisciplinary working as CPA did. However, relationships with SS had always been good.
	Doc	Forms multidisciplinary.
3 Preparation and support	M081	All CPNs had some training provided by SS. and "our own training department ". Currently manager provides supervision, but "we're hopefully going to have a couple of [supervisor] posts in the future".
	N082	"We went through the training first to run the pilot then the training was generalized"."That was a three-day in-house joint HA and SS collaborative training". "It's difficult to know what more they could have done at the time". "I would look to my line manager for support. We also have peer supervision ... and shortly we're to have two senior H grade nurses appointed for this. So I feel there is support". "Professionally I'm accountable to my line manager. He's from a nursing background".

3.4.6 Pattern-matching (3) case 6 (cont)

Proposition	Source	Evidence from data
4 Case management model	M081	CM about "one person activating a lot of services". CM either by SS or CPNs. But "we're paying a lot of money out ... so it's making us think and look differently at providing services". CM similar to CPA: "they tend to be fudged in together". Criteria similar to section 117 criteria. Care forum holds budget: "I think CPNs themselves wouldn't like it. I think it would be such a minefield that it would cause a lot of stress". Budget devolved to manager level would give autonomy. "It [CM] allows people to be advocates for people with long term mental health problems".
	N082	"You go for the CM option where you need to secure monies for a client to go into residential or nursing homes". "I think that it's difficult to see CM other than in terms of financial control". Assessing for financial need not problematic. Uses same documentation as SW CMs except for specialist assessments. Similar to CPA. Care plan forum are budget holders: "in no way do we have a budget as CMs" though "the idea was that care managers would buy care with a devolved budget for their clients". Unsure whether budget will devolve in future. Involved in care delivery but "you've got all sorts of conflict going on because I do actually function as a provider and as provider with responsibility to a purchaser". Advocacy can be tricky when you've got conflicts of interest. But generally able to be an advocate more than before.
	Doc	CM documentation provided for nursing home assessment, funding, specialist assessment and service delivery agreement - all shared agency documentation.
5 Practice conflicts	M081	"We're in an under-resourced team ... most of them have got too big a caseload ... we haven't got the time". "More and more paperwork rather than seeing clients" and "a lot of stress". "There's lots of referrals we receive for new assessments we just can't take on. So what we've tended to do is only pick out the more vulnerable and the more difficult ones" and "we tend to give them only a limited time". Others "we try to pass on as much as possible". Also specializing: "one of the CPNs is just now looking at setting up a group for people who are hearing voices with SS". Also "looking at a change in the grade mix ... so we can provide better quality care" and plan to develop packages more for people with long term mental health need, offenders etc. Overall "a small population are getting a good service".
	N082	It was time consuming doing initial assessments and placements - "the paperwork at that time was horrendous" and "it is time away from your mainstream role ... how you sort it out without extra resources is difficult to see". Cannot take on all referrals: "the general principle which has been established is that it's the person who's had the longest contact with the client". "I feel that in general we do meet needs" but "I think we could meet needs better" with more community resources". "There is a form for recording unmet needs which then goes to the service manager or care plan forum. As I understand it very few have been completed". Also "quite objective" about prioritizing according to clinical need. "You do get job satisfaction".
	Doc	Assessment summary mentions target group for CM.

Pattern-matching (4) case 6

1. Professional issues

Respondents agreed on the suitability of nurses for CM in terms of the continuity provided over long periods of time (✓). CPNs are appropriate CMs (as are DNs & HVs) because of a focus on assessment for residential placement, similarity to CPA and existing work, good use of skills and opportunity to specialize, though the CN mentioned the future possibility of designated CMs who can give post more time (±). The manager feared for CPNs as team was so small and vulnerable (✓).

2. Organizational issues

The manager expressed dissatisfaction with the narrow organizational focus of CM in the locality on residential placements (✓). Both manager and CN felt some degree of involvement in CM implementation, which was "bottom-up" (x). The major changes were felt to be very stressful (✓). Although there were interagency problems, these were mainly with medical, rather than with SS staff, and were limited largely to the management, rather than practice, levels (±).

3. Preparation and support

Preparation for CM, on an interagency basis, was felt generally to be adequate (x). Supervision was uniprofessional, with no problems expressed and plans for future development and formalization (x). The CN felt accountable to the (professional) line manager but volunteered no problems with this (x).

4. Case management model

The CN appeared to see CM more in terms of a finance-driven role than the manager (±). Further, while the manager felt the current level of budgetary devolution to the care forum, was appropriate, the CN understood that what should be happening was devolution to individual level (±). Both respondents mentioned provision, though the manager questioned the appropriateness of some of the care, while the CN saw conflict with the purchaser focus (x). There was no mention of problems with CPN recognition (-), possibly because

of the good relations with SS. The manager felt CM allowed for an advocacy role, while the CN mentioned conflicts of interest here (±).

5. Practice conflicts

There was a strong feeling that community resources were inadequate (✓) and also that pressure of work, especially initially, detracted from care (✓). In general, needs were met and users involved through a number of strategies: narrowing eligibility criteria and prioritizing, limiting time per client, use of voluntary agencies, specializing, changing grade mix and recording unmet need (✓).

3.4.7 Pattern-matching (3) case 7

Proposition	Source	Evidence from data
1 Professional issues	M121 N122	CM role about enhancing existing work for CPNs whose caseload included a number of patients transferred to CM, though "if we'd done it again we'd have done it differently". CM "not something that's peculiar to nurses". "I've deliberately steered away from the old nursing process". CM also "about promoting the care programme" as CM clients also on this. "I actually went outside most of the professional boundaries". Though role no longer formalized "I'm getting round that basically because of the type of personality that I've got ... you need someone with a broad spectrum of knowledge to be able to coordinate ... I think you've got to have a specific attitude to be a CM" and "the research project indicated that ".
2 Organizational issues	M121 N122	Involved from the start. "We really in fairness haven't been rushed". Moving in that direction irrespective of community care policy: "already aware of the needs of this particular group anyway and running parallel to this was a separately running research project". "We have worked very closely with other agencies ... we've got very good links, certainly at operational level, with SS". But GPs not familiar with the (CPN) service. "There was a fair amount of antagonism" due to project gaining funding at a time of cutbacks. Focus in district on long-term mentally ill. Change largely came about with the RDP project. Involved in design of assessment form. "The change is going to be an awful lot of confusion at first" due to end of project and other reasons. Future will involve more change. Now "for me, I'm feeling quite a sense of loss really from the research project". "You don't have the challenges that professional demarcation has".
3 Preparation and support	M121 N122	Preparation for CM "all very highly organized. Then they attended regular top-up training sessions and conferences". No specific preparation for role: "the education and training we had was ongoing as part of the RDP project but I think I stood well anyway because I'm committed to long-term mental health and rehabilitation". "I get my professional support from my colleagues who are community nurses. I get no professional support from my line manager at all, which is sad because the support that we need for this job is crucial". "During the project I was professionally accountable to [nurse manager] but from a day to day working point of view I was accountable clinically to my colleague who was a SW".

3.4.7 Pattern-matching (3) case 7 (cont)

Proposition	Source	Evidence from data
4 Case management model	M121	CM based on "scientific" needs assessment and delegation of responsibility "to the most appropriate member of the team". Team leader a SW. "The CMs who were appointed were seen by certain already existing staff as encroaching and taking over".
	N122	"To me, CM is about working without barriers across the services to coordinate and provide care that's required to support people's long term mental health in the community". Not currently a budget holder though "we did have a budget when we were part of the research project". Doesn't see advantage in devolving budget to individual level "because I've come across many examples where individual service budgets have been grossly overspent". However "I've been able to negotiate with the purchaser, the local authority". Does not see conflict in assessing and budget holding. Involved in "providing a lot of the care needed ... for this particular client group I don't think you can get the results effectively by not giving care yourself". Also "it's about advocacy". CM not particular to nursing. In current climate "we're still perceived as a threat" because of redundancies, while there was funding for the project.
	Doc	CM assessment form used RDP model.
5 Practice conflicts	M121	"What's happened now is the funding has dried up - obviously it was time-limited - and we've adopted and adapted the philosophy of CM within our own service provision. The clients who were on the CM caseload have had to be absorbed into our service provision" though "it's been reduced... the people on the receiving end of the services have benefitted from it and their expectations go sky high and when you have to withdraw it's very, very difficult". "We've had to prioritize, obviously". But "we haven't abandoned CM at the end of the pilot - we've seen the benefits of it and integrated it with the existing services. We're well on the way to involving users and carers in the decision-making" and "it was evident form the report that because of CM the quality of people's life had improved significantly. There are one or two clients who ... because of CM managed to stay out of hospital."
	N122	"I'm burdened with the responsibility of two other colleagues' work as well" and extra paperwork. Does not experience job satisfaction at the moment as cannot develop the service. Able to take on all clients and most appropriately referred. Use of criteria for referral: "the essential thing is the length of time the client needs work ... the amount of dependence the client has got". But since the pilot the criteria have broadened out. Involves carers in assessment. Not always able to meet clients' needs "but it's not about disregarding them ... it's about remembering them and maybe coming up with an alternative for the time being" also documented in assessment. Overall "the research project - the way we delivered the service - is the best thing for the long-term mentally ill that I've done in twelve years ... without a doubt, doing CM and being able to work across the boundaries is really rewarding because you can deliver the goods".

Pattern-matching (4) case 7

1 Professional issues
It seemed to the CN that CM was a concept which nursing would have to adapt to, rather than govern, in terms of traditional ways of working (±). The same could be said for CPN work, according to both respondents, at least with hindsight; while the manager reported that it would have been done differently if implemented now, the CN talked about working outside traditional CPN boundaries, and the role being to do more with individual personality, attitude and maturity than a particular professional qualification(±). The CM did not talk in terms of role erosion, but the impression was that this was not an issue (x).

2 Organizational issues
The organizational infrastructure for CM made its introduction fairly smooth, based as it was upon the same principles and a focus on the long-term mentally ill. (x). Both manager and CN felt involved to some extent in CM planning (x), but political and structural changes outside their control (including the discontinuation of the project) were emphasized by the CN which were hampering CM development (✓). There had been good interagency collaboration, especially with SS, at all levels, and this had only been threatened by more recent organizational cutbacks (x).

3 Preparation and support
Preparation for the role was good, but only as part of the research project and the CN spoke of his own experience and attitudes as being of equal importance (x). The CN spoke of inadequate support from his manager, compensated for by support from his colleagues (✓). During the project, accountability was split professionally and operationally, though this was not seen as problematical (x).

4 Case management model
The CN talked of the advantages of an ability to negotiate with purchasers (✓), although the budget was not devolved to individual level (which would not be appropriate in any case) (✓). Both respondents mentioned the importance of service delivery (✓).

There were problems for CMs in being accepted in a specially funded role against a background of cutbacks and redundancies (✓). The CN supported an advocacy role, with no mention of problems in this (x).

5 Practice conflicts

There were particular issues surrounding the lack of resources and time here once the pilot project had been completed, with the attendant problem of meeting clients' expectations (✓). There was also the problem of absorbing the work into an existing full caseload and extra paperwork (✓). Strategies included prioritization according to dependency, integration of the project into existing services and documenting unmet needs, finding alternative solutions where possible. CM allowed clients to stay out of hospital, involved users and carers, enabled swifter action and was rewarding for practitioners (✓).

3.4.8a Pattern-matching (3) case 8a

Proposition	Source	Evidence from data
1 Professional issues	M141	"There's always quite a muddle ... whether it is case management or care management". "I think people were sort of dabbling in it without doing it formally". "In some ways I think if it's [CM] provided by a non-clinician it allows the clinicians to get on with the work of actually providing the care". Nurses are "very practical". "It depends on the person of course ... you've got to have a high level of commitment". CN came to be CM "basically because her interest and commitment is to the people with enduring mental illness".
	N142	"I actually call myself a care coordinator ... because I don't like the term CM". But some confusion over whether the named assessor for community care is the CM, though "I'm a nominated community care assessor". Also linked to meetings of section 117 of Mental Health Act every 3 months. Very different from traditional CPN role where ... "stuff like benefits, housing, social needs were ignored". "My training is in nursing, but ... I'd actually like to let go of that bit". ... "I don't feel like a nurse any longer ... being a psychiatric nurse is different from being a general nurse". Happy for non professional administrator (eg manager) becoming a CM.
	Doc	CPA process for area indicates similar core phases to CM.
2 Organizational issues	M141	Organization stems from CC legislation and manager was involved in planning, though not in CM working group. Joint (interagency team) work extends to all phases of CM as "equal partnership". But some lack of understanding by team of CNCM's role. Also GPs "a very difficult bunch to work with".
	N142	No district wide CM set-up. Separate teams "do their own thing". Role "evolved". Change very marked: "I think I will spend the next couple of years still getting my head around all this". No problem with agency boundaries: "we do work quite closely together". "I've got a very good relationship with both the SWs. Any conflict "is probably because we've got different levels of commitment".
	Doc	community care assessment form for mental health states named assessor should coordinate input of other disciplines.
3 Preparation and support	M141	No preparation for role. For the rest of the team "we read about it ourselves". "I see my role as supervising [CN] with the administration side of the CM ... our consultant psychiatrist has agreed to audit the clinical side for her and supervise her". No nurse manager but a nurse present on clinical advisory group.
	N142	Preparation for role "only what I did myself ... my nurse experiences". But "no formal preparation" though would have liked some. "Actually I've got quite a few supervisors ... the Consultant, the manager ... the community care manager SW ...a SW - he's a trained psychotherapist, so I have got quite an extensive supervision set-up". "I'm not entirely sure how or why I would want supervision from a nursing point of view". Accountability to "my clients ... I suppose my manager ... we have just had a kind of nursing adviser appointed".

3.4.8a Pattern-matching (3) case 8a (cont)

Proposition	Source	Evidence from data
4 Case management model	M141	"There are three models ... and I think we sort of took a bit each ". Budget centrally held but would welcome devolution as "you're able to plan your own resources at operational level". "Case management isn't about giving the care yourself, it's more about managing it, monitoring it, keeping control of it".
	N142	"I organize people's care, a very thorough assessment of their needs, which is ongoing, and then managing the resources". No devolved budget and "I don't know that I would particularly want one". "I'd actually moved myself away from therapist's role in the sense of doing cognitive behaviour therapy. I felt that getting into a therapist's role put me in a position that I couldn't actually deal with". But now planning "that I go back into the therapeutic role and more appropriate people take on CM". Found no time for brokerage and therapy. SWs act as both assessors and purchasers "and it's not working .. it's a very difficult situation". Felt able to act as advocate for case example.
	Doc	Use of MRC needs assessment documentation and community care assessment form for locality which is for use of "named assessor" and links to SS IT system. Suggests assessment and service provision are difficult to separate and also that assessor should be "receptive to any advocacy service which the service user may wish to engage". CPA documentation uses phases of CM.
5 Practice conflicts	M141	Gave account of large caseloads of 40+, lack of time and few resources. Long term clients maintained on caseloads with acute referrals from GPs coming in constantly. Dealt with this by prioritizing: "we'll be looking to ... focus on people with long term illness, schizophrenia ... I think they are the people that need it most". Aim to give choice to clients and "I can see the change in our clients certainly". Gave examples of difficult-to-engage clients being maintained out of hospital.
	N142	Felt caseload inappropriately high. "I haven't actually had the time to put as much in as I'd like to". Does not take referrals now as "we get very few because we're actually in contact with most of the people". "The people that I've focused on over the past 6 months ... have been people that have been discharged from hospital from a section 3 of the Mental Health Act". Able to incorporate carers into assessments and not felt restricted in accessing resources for clients: "It is time-consuming, but I'm not particularly keen on identifying people's need and then saying I'm sorry we can't do anything about it". Accesses money from community care budget, benefits or charities. Case example has improved under CM and may be discharged soon. Has job satisfaction though "I would be more satisfied if I could do more of it, but that is purely a time factor".
	C143	Not involved in decisions about care at first but later offered a CPN and felt involved. CN "always been there and able to advise ... it was just sort of helping you get back into life again". Had not noticed any change in ways of working and "to me it's amazing, the system".
	Doc	community care assessment documentation stipulates information to be shared with service user.

Pattern-matching (4) case 8a

1. Professional issues

There was evidence from both respondents of confusion locally about the remit of case managers and a consequent doubt whether nurses can identify with the role; both questioned whether a clinical background was necessary at all, while the CN felt no current allegiance to nursing (x). The CN also felt that CM was very different from the traditional CPN role, although it linked with section 117 and (according to documentation) to CPA. Further, the manager felt the adaptability of mental health nurses, plus personal interest, made them suitable (±). There was no evidence of feelings of professional deskilling (x), possibly because of the changed professional allegiance.

2. Organizational issues

The CN explained that CM was not well integrated locally, though, according to the manager, the impetus was the community care legislation (✓). The manager felt involved in implementation (x). The CN was very much feeling the effects of change (✓). Interagency relations appeared to be good from the practitioner's point of view, though the manager expressed some reservations, especially regarding GPs (±).

3. Preparation and support

There was no official preparation for the CM role, though this would have been appreciated (✓). Supervision appeared good, with the CN expressing no particular need for a nurse supervisor (x). Accountability lines were not presented as problematical (x).

4. Case management model

Respondents seemed to have a clear conceptualization of CM, though the model adopted locally was an eclectic one. There was an implicit responsibility seen in CM for purchasing (✓), with no devolved budget and differences of opinion as to whether this was desirable (±). The doubts expressed above about the CPN suitability for the CM role were further highlighted in the interesting mutual decision for the CN to move back towards a therapeutic model of care, with

the manager becoming the CM - thus casting doubt on the suitability of provision within a CM remit (x). There was no specific mention of problems with recognition of CPNs as CMs *per se* (x). Although the CN felt able to act as advocate, this may have been outside the CM role and the documentary evidence referred to separate advocacy services, thus supporting this (✓).

5. Practice conflicts

The manager emphasized lack of resources and both professional respondents mentioned lack of time, however the effect of this on "user emphasis" appeared minimal, with some examples given of positive outcomes (±). Similarly, high caseloads were mentioned by both, though the number of new referrals was debatable(±). There was much evidence of strategies used to promote quality, such as targeting and imaginative ways of accessing money (✓).

3.4.8b Pattern-matching (3) case 8b

Proposition	Source	Evidence from data
1 Professional issues	M144	CM has "been going for years. So it really has been an extension of that". Professional, though not necessarily nursing, background important in managing CM. Currently being pushed to become generic workers and "historically psychiatric services have resisted that ... the CMs want to maintain a specialist service for this group and not get swallowed up".
	N145	"I've considered it so far as an extension of what I did previously because my caseload is made up of people with ongoing psychiatric problems". "Up until about a year ago I was very much a mental health worker" less specialized than now. .
2 Organizational issues	M144	"Many of the decisions made about care management really were an extension of what was already going on". But "very much involved" in subsequent developments. "Community care legislation was universal and covered the whole of Britain. Ignored was local good practice, and I think what we've done is stayed closer to local good practices". "I think my role will change ... the flatter hierarchy that Handy talked about" will leave a gap between management and clinical work. "We've got SWs working very much as part of the team and it looked like if we went the other way [as government stipulated] and said 'right SWs will do all assessments and we'll just be providers', we'll lose them from the team and so we'll lose the group dynamics and the qualities they bring". But problems with SS boundaries not being coterminous with health.
	N145	"It's been slightly piecemeal in this district ... we're a community psychiatric team, S [case 8a] have a community mental health team and T [case 8c] have a community mental health resource centre". Soon to be involved in adapting assessment form. Feels in transition at moment and underlined changes. Works closely with medical firm, especially consultant psychiatrist. Also "my links with SS are good" and there are two SWs in team. Regular meetings held. GPs also "very important" and "we keep them well informed". But not everyone in team specializes in long term mentally ill as they have other specialisms.
3 Preparation and support	M144	"We've actually had joint training with SS that's been promoted by a joint working group that I'm part of ... so far it's been three-day courses, a one-day course and a two-day course and we're looking to set up more". Sees role in terms of "maintaining a quality of service through either direct supervision or maintaining supervision". Questions like accountability of CPN to SS "really have to be worked through in a lot more detail. We're in limbo until we can work that through".
	N145	"SS sorted out some training event for the community care assessment which were useful up to a point. We became community care assessors overnight. We weren't trained". Attended conference in 1988 where developed interst in relapse prevention. Felt there was sufficient professional support. Accountable to manager but "clinically, I'm probably more accountable to the consultant psychiatrist and the ward team". Saw no conflict in this.

3.4.8b Pattern-matching (3) case 8b (cont)

Proposition	Source	Evidence from data
4 Case management model	M144	Used both terms "case management" and "care management": "case management was thrown out because we can't refer to 'cases'". Prefers to say CN "manages his caseload". Manager's role "on a practical level I think it's like helping to coordinate CMs" and also has own caseload. "We're saying that the functions of assessment and provider should be split but it can be the same person fulfilling the same function". Also "I think we're being directed to become brokers more than providers ... the other direction we're being pushed locally is in becoming generic workers and actually being hooked under the general community services". Currently a budget manager, not budget holder but would welcome being latter. Regarding devolution to CM level "the question I'd have to ask first is for what benefit ... I don't really think we've thought through it enough ... by the time it comes down to the individual clinician, it's so much of a pittance, it's not worth it".
	N145	Terms case and care management "tend to be used interchangeably without any specific meaning attached to them". CM is "different from keyworking in that I have more responsibilities". "The keyworker does everything that the patient needs them to do". Sees self as in a coordinating role. Linked to section 117 reviews. Immediate boss has budget but aware of costings. There would be advantages in budgetary devolution as "I suppose it brings the money somewhat closer to the patient" although "I've got misgivings about budgets coming down lower and lower because we'd than have to develop accountancy skills". Involved in care delivery "because unless you're visiting the person every week ... you can't be doing relapse prevention because you can't see problems coming". "The big thing about community care legislation is it separates off assessment and provision". However "I perform a dual role - I assess and provide". Sees self as advocate in many cases and gave example.
5 Practice conflicts	M144	"We've changed from service-led to needs-led" though "I think there are very strong dangers now with the purchaser requirements of suddenly becoming service-led again". Feels problems with contractual agreements and "as a clinical manager I get torn both ways". Could meet target numbers with concentrating on "mildly anxious people" and providing no service to long-term ill. Further problems with brokerage role where "we've got major problems with quality because we can buy in services left, right and centre but who knows what quality they're going to be".
	N145	Not always able to meet client needs due to shortage of resources. If needs cannot be met, care is largely unprovided. Further noted "encroachment on clinical time". Many on caseload "it would seem like forever". Use of targeting and "there's a rule of thumb involved, that is that I prefer to take target people that are relapse prone as discharge is being approached". Also focus on psychiatric morbidity, rather than mental health. Able to involve carers. Overall has job satisfaction.

Pattern-matching (4) case 8b

1. Professional issues

There appeared to be agreement that nursing sat well with CM, to the manager because nursing characterized the professionalism necessary for the role, and to the CN because CM represented an extension of existing work (✓). Further, CM was very much seen in psychiatric terms, specifically to the CN because it allowed for professional specialization within this (✓). There was a detectable feeling of potential for marginalization of psychiatry on the part of the manager, though the CN felt the move to specialization was overcoming this (±).

2. Organizational issues

The paradox apparent in the explanations here may account for the unusual set-up underlying the decision to designate the original case 8 as three separate cases (a, b, c). While the CN described the organization of CM as "piecemeal", this lack of strategic planning was seen in a positive light, since it allowed for the development of local "best practice", which government directives ignored (±). The manager felt very much involved in the implementation process and the CN was adapting the assessment forms (x). However, change was anticipated in a generally negative light (✓). It was felt that good interagency relations had largely been maintained by ignoring government guidelines (x).

3. Preparation and support

Although joint interagency training was considered fairly useful, the CN felt that preparation to became designated community care assessors was inadequate and that his own personal professional development was more useful (✓). Professional supervision appeared good (x). While the CN saw no conflict in the diverse lines of accountability, the manager felt the issues needed working through (✓).

4. Case management model

There was a general feeling that CM was poorly defined, with links to keyworking and section 117 legislation as well as community care

policy. The manager appeared to have what some literature has seen as a "care", as opposed to a "case" management remit - coordinating CMs, though also carrying a caseload. The crucial policy seen as being promoted by the government was a separation of assessment and provision. The manager felt that the government push was for CMs to become brokers and the CN felt he fulfilled a dual role (✓). Budgetary devolution was welcomed, though not to CM level, because of the small amount of money available for dubious benefit, and the need for accountancy skills (✓). Provision was certainly seen as important in specialist work by the CN (✓). There was no evidence of problems with CNs being recognized in the CM role (x). The CN felt able to act as client advocate within his model of CM (x).

5. Practice conflicts

While the CN noted a shortage of resources and time, and the effect of this on care provision, the manager perceived the main threat to quality lay in the organizational requirements to fulfill contractual agreements on the one hand, and the lack of control over care delivery which accompanied the brokerage model on the other (±). Again, while work pressure, in terms of high caseload numbers, concerned the CN, the manager felt that meeting targets sidelined the issue as they could be easily met but with no quality guarantee (±). The CN described the focus on psychiatric morbidity and relapse prevention as one way of coping with these problems and remained optimistic in terms of involving carers and his own job satisfaction (✓).

3.4.8c Pattern-matching (3) case 8c

Proposition	Source	Evidence from data
1 Professional issues	M147	"Nurses ... can be named assessors for community care ... but I think they were doing that anyway" as "we have all got some experience to bring". "I don't have a clinical backgound ... I think I used a lot of intuitive stuff". But "I think the clinicians were reluctant to be called 'CMs'".
	N148	"C [manager] is a non-clinical team leader. I think that if there was a specific discipline in there that might promote interdisciplinary rivalry". GPs "are quite happy" for CPNs to take on role.
	Doc	Service guide states CPNs to be members of team and one function is "comprehensive CM".
2 Organizational issues	M147	Practitioners from different areas locally work in different ways. Although community care has formalized a way of working "I don't think it's as good". Referral direct to team is quicker. Anticipated future change to being part of new negotiations for contracts. Multidisciplinary team joint funded and "over the years we have broken down the professional jealousies and that is the way we are all committed to work". Good liaison with GPs.
	N148	Expressed reservations about organizational structure: "I think it could be much easier sectorized and structured", as "there is confusion in it". "I have just been involved in the group planning discharge for people that will need a case manager". "All the members of the team ... would be perceived as community care workers". "I think we are fortunate in the way we work here in that I don't think anybody has got interdisciplinary problems". Anticipates change: "I think my role is going to fluctuate a lot.
3 Preparation and support	M147	"I think they have had a lot of money spent on them training-wise, Everybody is interested in different things, myself and IM [CPN] are doing a degree course, which gives us ideas that we bring back". "The community care [training] we have had "wasn't anything we hadn't done before". "This Health Authority did give us some training in supervision. I feel that staff choose their supervisors well and they look at their CM within the supervision". "I don't actually supervise them".
	N148	No specific preparation for CM but related variety of experience through different posts. "We have had two specific training days" which was "quite handy". Also "we are currently doing a degree". "We have got a supervision package where I supervise two of the other CPNs and I am supervised by S who is the SW so there is a very flattened hierarchy". Also peer support. "I think you have got really accountability to yourself because a lot of the work you do is in a situation where you haven't got a lot of backup".

3.4.8c Pattern-matching (3) case 8c (cont)

Proposition	Source	Evidence from data
4 Case management model	M147	Prefers term "keyworker": "I think the clinicians were reluctant to be called CMs because they know you are responsible for that person in total even if you don't have intervention. CMs do not always do an official community care assessment if grants and other monies are available. Own role "more administrative than managerial really" and also "I'm the communicator, the coordinator". Not a budget holder "but there is talk about us, the team leaders, holding the budget at some stage. I don't really mind because I get a copy of the budget from my manager".
	N148	"The current agreed phrase was 'community key worker'. On the 117 meetings they have now changed it to case manager. It is interchangeable. You are their broker for care", entailing CC assessment and activating plan. Sees it as very different from conventional CPN role. Not responsible for budget but we generally get information fed back to us". "I don't see myself as a purchaser" but as broker "I will negotiate for services". Not sure about budgetary devolution: "it really depends on if at the end of the day we would be able to get better facilities for the clients". But "as long as you are given some basic accountancy input ... it would be OK.
	Doc	Psychiatric assessment form used as well as community care assessment.
5 Practice conflicts	M147	"We know there is a need for something we can't provide and we want the money to do it". Finds currently "it is a very tortuous route to try and find where some of the money is". Coping by targetting long term/enduring mental illness, setting up innovative services. If necessary would "do a community care assessment which would highlight need and we would ask for money" otherwise if identified a real need "we would try to get it somehow". Positive about outcome of CM. Gave eg. "It has given the clinicians affirmation about their work". Overall "It's such a good way to work ... this felt so right".
	N148	"I would think if you had 25 people who were new there would be too many". Also "we are actually a very small figure in terms of expense". Sometimes identifies needs which cannot be met, eg rehabilitation needs. "At the moment we have not had to make a waiting list for anyone ...but most of the people ... have been picked up". Area has not had the problem of large numbers from hospital closure. Therefore priority goes to "anybody that has been in the service for over a year", with CM allocation according to appropriateness and size of caseload. " Even so there are always people that have various problems and a problem is a problem and that is the bottom line". Able to look to alternative resources through "network system". Involves carers in CM.
	C149	Did not feel involved in decision to come home from hospital. Named CN as a help in becoming independent.

Pattern-matching (4) case 8c

1. Professional issues
Although the local policy was for nurses to be "named assessors" and CMs, there was an impression from both respondents that a professional background was not necessary to the CM role (x). The implication was that it was not by virtue of the CPN qualification that the CN was suited to the role (x). Despite, or possibly because of, a distancing from the profession, the CN did not express fears of role erosion and uncertainty (x).

2. Organizational issues
The local organizational arrangements for CM were criticized as being fragmented by both respondents (✓). However, there was a feeling of involvement in shaping future directions (x). Change was both a past feature and a future expectation, giving rise to some conjecture (✓). Expressions of interagency teamwork were all positive (x).

3. Preparation and support
Although there had apparently been considerable investment in continuing professional development in general, the CM-specific training had been minimal and the CN felt it was experience, plus their own investment in education, that made a difference (the CN and manager were both doing degrees) (✓). However, the supervisory system, within a flattened clinical hierarchy, and with preparatory input, seemed to work well (x). The CN felt a strong sense of self-accountability, as if this was to be expected (x).

4. Case management model
Though there was some confusion regarding title, the CM role was seen within the community care changes and, generally, as something with more responsibility than the conventional CPN role. CM was seen largely in terms of a brokerage function, but not purchasing (x), with the community care assessment providing access to the necessary finances when other sources were inadequate, and the manager acting as the coordinator (again resembling the care manager role previously described). Budgetary responsibility was

seen as being most appropriately devolved to manager level, unless there was clear indication of client benefit and sufficient preparation in terms of accountancy skills (✓). The CN clearly saw himself in terms of a service provider (✓). There was no evidence of problems with recognition for nurses in the CM role and the GPs were happy with this (x). There were no data on advocacy (-).

5. Practice conflicts

Both respondents expressed a need for more resources (✓), although the issues of over-large caseloads was not a major problem due largely to there being no local hospital closure (x). Even so, quality maintenance strategies were in evidence, including targeting the long term ill, setting up services, looking at alternative provision and allocation of new clients. Overall it appeared that clients felt well served, carers were involved and practitioners were happy in their jobs (✓).

3.4.9 Pattern-matching (3) case 9

Proposition	Source	Evidence from data
1 Professional issues	M161	"'I don't know if it is appropriate" that nurses be CMs along SS model. "I don't particularly see [CNs] as care managers. When I became a DN we were purely district nursing and we had a good service then ... our role became a bit smudged". "When the community care plan first came out there was not any mention about DNs joining in with these services".
	N162	Sees CM as "just part of their role". But fear for encroachment of home carers taking over certain nursing tasks "now suddenly it seemed to be handed to SS to decide whether nurses are needed and a lot of them have not had nursing experience". "It was suggested that nurses should not go any more [to joint allocation meetings] but that means nurses are not going to be in any of it so it is a little bit of a worry".
	N165	"It seems to work the way we are [with nurses only responsible for nursing] because they [SS] don't know about nursing needs". Case example has care manager from SS but "we don't have anything to do with her".
	Doc	No mention of nurses as CMs in code of practice for combined home care and community nursing service. Care plan purely nursing.
2 Organizational issues	M161	Project involved "a big reorganization ... a big upheaval". It was not extended due to "political reasons". History of demarcation disputes between DNs and home carers, "then we set up meetings with SS and "they would do a joint assessment and a joint visit" and "DNs did teaching sessions with home carers".
	N162	"They [SS] do ask for a DN to be present at their [referral] meetings everyday" along with representative from other professions. Felt this was inefficient and led to delays and that nurses should be more involved from the beginning. Now it is "all SS". Spoke of "all the changes" which meant that "everyone is quite disheartened", though anticipated less in future. Also there was lack of feedback. Care plans purely nursing - SS CMs have different ones (though similar). Although "we have quite a good rapport with one home care manager", felt there was a gulf between the services.
	N165	Feels that community care in area is working well. "SS liaison is quite good. Every day we have a service choice meeting and one of the DNs attends". But also "I don't know how they work in SS ... we never hear any more from them after we've picked up the referral". No contact with case manager of case example, due to different areas. Also documentation not shared.
	Doc	Code of practice for staff mentions "combined community nursing and home care serice" which "will operate in accordance with the joint policies and procedures issued by the relevant authorities".

3.4.9 Pattern-matching (3) case 9 (cont)

Proposition	Source	Evidence from data
3 Preparation and support	N162	"The only bit of training I had was actually during the [DN] course". Thought this was useful, but would like more. SS promised some study days but nothing materialized. Felt that at the moment professional support is lacking but put it down to the changes. "We are professionally accountable to the three managers" and "to be honest, we are having a few teething problems being accountable to someone from a non-nursing background".
	N165	Preparation was in the form of "booklets on community care, the ones issued by the government". There were no joint sessions with SS: "our manager did all that and we got the feedback from her". Felt professionally accountable for actions to nursing line management.
4 Case management model	M161	Described the project in terms of DNs managing home carers "but with the home care looking after the financial side". SS CMs "are entirely different to this organization". If DNs identify a social need "I think that should be taken off them". "We are both providers".
	N162	Saw CM in terms of referral to the appropriate services. If SS then DN would hand over and not follow up. No real difference from traditional DN role. Nurse manager holds budget and though "each sister does have an individual budget ... we are not told what it is". Would like more control as "you need extra resources". Currently involved in care delivery, but "this should be changing now and ... we should just be doing assessment". "I think all the DNs should really be an advocate for the patient".
	N165	CM seen in term of coordination, delegation, assessment and referral. However, responsibility for clients as CM is only in terms of nursing needs, though assesses social needs. Provides care though feels assessment is the important thing and in future will not have time for much else. Feels DNs can be advocates: "I think we do in fact speak up for them - it's very difficult".
	C166	Stated "if I need anything, I phone for the nurse", though later stated no one individual was responsible for care overall.
5 Practice conflicts	M161	Talked about huge amount of work coming in and one reason CM not appropriate for nurses is that it would take time from patient care.
	N162	Unable to meet needs always due to inadequate services and staff. Commented on caseload increasing continually though it felt manageable due to numbers in the team. Meetings with SS time consuming. No referrals turned down. No criteria used for referral to different disciplines from meetings and difficult to prioritise with no control over budget. Some attempts to look for alternative provision though may not be adequate and unmet needs documented. Has job satisfaction: "overall ... it's one job I have really felt quite content in actually".
	N165	Takes on all referrals and not targeting as SS do. If unable to meet identified needs will usually hand over to SS. Feels community care "has been a good move, maintaining people in their own homes".
	C166	Did not feel involved in deciding what help was received at home and not as good now as it was.

Pattern-matching (4) case 9

1 Professional issues
The manager felt that nurses were not suitable for the CM role as practised by SWs, and the CNs' support appeared to be for a different concept, as they had little to do with SW CMs (x). All seemed to wish to retain the DN role in its traditional form (x) and the CNs were concerned about encroachment from home carers (✓).

2. Organizational issues
The organizational set-up appeared to be largely SS led, with little integrated planning (✓). The manager was initially involved in planning meetings, and the CNs in service choice meetings with SS, but these were being relinquished, almost by choice (✓). There had been a big reorganization, which was "disheartening", as community care was implemented (✓) and, though there was evidence of superficial joint working to meet the requirements of the project, there was a notable lack both of communication, at least at the service level, between the two agencies, and of knowledge about how SS functioned on the part of the DNs (✓).

3. Preparation and support
Preparation for the post-community care role had been minimal (✓), and professional support appeared to be lacking, with no evidence of clinical supervision (✓). Accountability, though strongly felt, was problematical and not focused (✓).

4. Case management model.
To the manager, CM meant managing home carers, while to the CNs it meant little more than the traditional DN role, with an emphasis on assessment. There was no responsibility for purchasing (x) and the budget was devolved to nurse manager level, but with little involvement on the part of practitioners (✓). There was currently significant involvement in care delivery (✓), though it was anticipated that this would reduce in favour of assessment and delegation only. There was no mention of recognition by SS, but as there was no attempt to assume a holistic CM model, the lack of data

is not significant (-). It was felt that DNs could, and should, be advocates (x).

5. Practice conflicts

Lack of resources (✓) and high caseload numbers (✓) were apparently compromising quality of care because direct care time was limited. To cope with this nurses appeared to be defensively taking on all referrals, but there were no specific criteria for nurse allocation at service choice meetings and, despite looking for alternative provision, there was a sense of "handing over" with needs still unmet (x). Despite this, there was some evidence of job satisfaction.

3.4.10 Pattern-matching (3) case 10

Proposition	Source	Evidence from data
1 Professional issues	M201	CM "was really a continuum of where we were at". "CPNs have in a way adapted quicker to CM [than SWs]". "We began to look at it and say well what is the difference between SWs and CPNs and OTs and what are the commonalities ... and we discovered that we all do the same job in lots of ways. If you want a high standard, you need to have people who are qualified and at the moment that is either through SW or through nursing. If they change to a generic mental health worker, it does mean following some course of study". CPNs are suitable as "you actually have a foot in both camps, because this is very much a social model, but you've come from a medical model, so you understand what the psychiatrists are talking about".
	N202	Suitable role for own training as "I think sometimes housing and finance do cause mental illness". Can do more as a CM than CPN as for many things "I'd probably have had to get a SW involved, because they were the purchasers. Now we can do it".
	Doc	Community mental health centre assessment form mentions "worker" rather than CPN etc.
2 Organizational issues	M201	Have community mental health teams in area and manager involved in their formation through working parties, which involved different agencies coming together. "Everybody completes the same assessment form" and "so things are beginning to happen ... from the ground up". "We're lucky that we work as a team" although "it takes a while to build up respect". "At the end of the day we're dealing with a pretty high risk group, so maybe that tends to pull people together". Things are still changing as "it's a process, isn't it?"
	N202	Involved in developing joint assessment tool which all CMs use. "We had a team building day" which was useful. There are some conflicts but "I think we have overcome them quite well". Also provides a service for GPs. Feels role will continue to change: "I think in the sense that we will be doing more and more actual CM ... and less providing".
	N208	Involved in devising assessment form. Previously "there was no coordination, we all did it different ways" but now "I don't think it's perfect but it's working. It's going to go through another change". Some conflict with other professionals: "you get disagreements but nothing major ... I think we gel as a team". Does not anticipate major future change to CM role.

3.4.10 Pattern-matching (3) case 10 (cont)

Proposition	Source	Evidence from data
3 Preparation and support	M201	There is joint training for CM, but "I have to say it was pretty light". Has learned a lot personally "on the job" and also undertaken management course and of "still at learning stage". Provides regular supervision for CPNs: "caseload supervision, client supervision. OK you can never get rid of your manager's hat but supervision is really 90% support".
	N202	No specific training for CM role though "we did meet with the SWs every month". Currently doing an MSc course. Concerned about support in the past, but now "we get the support at the moment". Accountability to team leader.
	N205	Training was brief with half a day on financial issues and two away-days with SS. Supervision is within and across disciplines and includes peer support.
	N208	Preparation was "a day povided by SS" which was useful though "it could have been a bit longer". Supervision with manager every 3 weeks, as do SW colleagues.. the support is there". Also peer support. Accountability to self, UKCC and service managers.
4 Case management model	M201	Described model as "a purchaser/provider team ... we've two hats", with retention of some, but not all, care delivery. Budget held at locality manager level and "for us, it's been quite exciting to be in the purchasing stream". Model "exactly the same" as SW CMs "there's no difference". Involves idea of "named worker" who can always be accessed by clients. Manager also involved in clinical side and familiar with all clients. During implementation "the viewpoint from the CPNs was that if we're not CMs we're going to be second class citizens".
	N202	CM means assessing client needs, organizing package of care, implementing and coordinating the management of care. Regarding financial needs "I needed more experience". Budget held by team coordinator but can purchase outside services directly". Still involved in care delivery as "we still see that as our role, maybe because I think we've a nursing background". Has not found this conflicts with assessor role "although I could see ... if you assess, you tend to be more ... subjective rather than objective". No problems with recognition: "everybody now knows that we are CMs, so they accept our referrals". Feels able to undertake advocacy role for some people.
	C203	Unable to articulate extent of CM role: "he gives me an injecion".
	N205	Feels able to be advocate in CM role.
	N208	CM about "being totally responsible for the care of the client. Before we had to rely on other professionals. It's now up to me to assess ... and provide that care". Also CMs are named person for client . Allocation of CM clients may be to any discipline. Involved in purchasing and provision which is "difficult wearing both hats because you do become aware of what the costs are". No direct access to budget and doesn't anticipate personal budget holding. But "the purchasing bit is a big difference... it cuts down time". Feels able to be advocate.

3.4.10 Pattern-matching (3) case 10 (cont)

Proposition	Source	Evidence from data
5 Practice conflicts	M201	In past had high number of referrals and all clients were seen but only briefly. "So when the change came we began to prioritise clients". Also shared clients within team to spread the load. Further, "there hasn't been a lot of provider sector in this area and ... there will always be deficits". But "at least we'll now begin to register if there is a need ...so we see it benefits the client.".
	N202	"We don't discharge patients" and "it became too much obviously". Also very short of staff and not always able to meet identified needs as "our main problem in our team is that with community care our main resource is us". But "we keep to a limit" with caseload and "we can find alternatives" including support staff.
	N205	Caseload too high with few discharges and more paperwork, and staffing is too low. There are occasional unmet needs identified. Operates criteria for client referral based on matrix score and there is a waiting list.
	N208	Not always able to meet identified need and "if there's a need and no facilities, it's documented". But clients are involved now in care, which is a recent change.

Pattern-matching (4) case 10

1. Professional issues

Although CM was felt to be something new, it was considered a natural development of professional CPN training (✓) with CPNs being particularly suited to the role, as they had so much in common with SW CMs and straddled both medical and social models of care (✓). There was some unease at the prospect of a future entailing a generic role with untrained CMs, as this may lower the standard of care (✓).

2. Organizational issues

There appeared to be some strategic planning for CM, with working parties set up, which the manager attended (x). All levels of nurses felt involved to some extent, though the CPN voice was only felt through the persistence of the manager (x). Change (present and future) was mentioned, but did not appear problematical - possibly because of staff involvement (x). There were some disagreements within the multiagency team, but these were largely overcome through conscious efforts at team building (x).

3. Preparation and support

There was a consensus that the formal joint training for CM was inadequate, but both the manager and one of the CNs were involved in personally arranged professional development courses which had been useful (✓). Supervision was well developed and considered good (x). Accountability lines appeared clear to practitioners, and no problems were volunteered (x).

4. Case management model

CM was perceived uniformly as based on the SS model, with significant responsibility for purchasing (✓), and budgetary devolution to manager/coordinator level, which gave CMs the access to funds which they needed (✓). There was also some care provision activity; however, though this was considered to be in keeping with a nursing ethos, it was also seen potentially to conflict with the assessment and purchaser role and there were mixed feelings as to whether it was, therefore, appropriate (±). Problems

with recognition of CPNs in the CM role were largely avoided by the assertive efforts of the nurse manager in demonstrating their role and expertise (x). Advocacy was felt to be an appropriate constituent of the role (x).

5. Practice conflicts

Limited resources, in terms of time, staff and care providers, were felt to affect the ability to meet needs (✓), as did over-large caseloads, attributed by the manager to a nursing reluctance to refuse referrals (✓). However, a move to prioritization was in evidence, along with a "sharing of the load" within the team and documenting of need for feedback to providers and finding alternative provision. Overall the feedback was that CM was now benefiting clients, and user involvement was a reality (✓).

3.4.11 Pattern-matching (3) case 11

Proposition	Source	Evidence from data
1 Professional issues	M221	"I don't think that we are still probably geared up to be the main part of the care management approach". "For some people, perhaps because of personalities, that hasn't come particularly easily". However, it has advantages as "it gives autonomy to the community nurse to act as CM". Also "it has formalized the way a community nurse can work".
	N222	"As a nurse I feel as if I'm not nursing". "It's doubtful whether you need a qualification to be a CM ... is there a profession of CMs, rather than SWs or CNs?" Also "we've got a poblem in that as a qualification RNMHs are very much under threat ... and we see CM as one of the areas where we could possibly create a niche for ourselves". CM is "like the nursing process - that's why we slip into it so easily". "It made logical sense ... it was more an evolution"
	Doc	CN as CM evaluation reports "all cases were specifically considered suitable for a nurse as CM because of their complex health needs as well as social care needs". "Consideration be given to extending the arrangements to include DNs working with people with physical disabilities".
2 Organizational issues	M221	"We had discussions about 12 months ago with our counterparts in SS to look at how we ... could effectively introduce the CM approach". Also "within LD sector we had a subgroup of which I was part where we discussed how we would work with SS". Felt involved in decisions. "It was quite difficult for everyone to get their heads round what this was about and initially we had some teething problems. But links with SS have always been good, with joint planning groups etc: "so whilst I think that there are times when it's a bit unsteady, I think that's probably more to do with personalities". Relationships also good at practitioner level. Communicated with GPs about CM.
	N222	"Basically I think CM is a good idea, but the way it's been implemented is atrocious. They forced it in from the top .. and it's so good it could be sold, it didn't have to be forced" and "they didn't think it through, they could have piloted it properly". The reality is that different areas have implemented CM differently. Impetus from CC Act: "It did change ... it's taken a little while to gain momentum". GPs have input "they're so automatic".
	Doc	CN acting as CM evaluation report emphasized sharing of documentation with SS.

3.4.11 Pattern-matching (3) case 11 (cont)

Proposition	Source	Evidence from data
3 Preparation and support	M221	"SS in particular really took a long time to ensure good preparation of its staff" but "I think from the health point of view, I don't think it's prepared us as well as SS". But liaised with SS about further training needed. CNs have supervision from manager, and from counterpart in SS. Currently looking at how to improve system. Accountability system "works out quite satisfactorily".
	N222	Has been on training with SS for CMs, which was useful as one session "totally changed my attitude to CM ... I got totally convinced about the philosophy". Saw training as necessary for CM, although nursing process background helps. "I am supervised by my manager, peer group, and by SS. But there's no problem there if personalities gel". "Professionally, I'm accountable to my line manager" but "as part of the team in LD you can sometimes have this dichotomy of loyalty to your team and loyalty to your profession, because it's a multidisciplinary team. Having said that, I find that in all these things, it's personal relationships that are the key."
	Doc	CN acting as CM evaluation report emphasized regular clinical spervision and feedback indicated this was useful, and did not lead to role conflict with line management. CNs also had "appropriate training" and have undertaken community care training modules with SS staff, paid for by SS.
4 Case management model	M221	Budget devolved to senior manager in SS, which is appropriate at the moment: "I think if we were actually to devolve it to the CM level staff would have difficulties". Involved in care delivery as well as assessment. "There was greater emphasis on SS being CMs than health staff being CMs ... it's probably more strongly led by SS". However "we're getting good rapport and reports from SS about the way they [CNs] function".
	N222	There is a problem with definitions: "care planning and care management are synonymous". CM also tied up with CPA and existing IPP (individual programme planning), "which can lead to complications". Does not mind doing financial assessments. Financial implications of care packages authorized by team leader who holds budget. It would add to conflict and stress if budget was devolved further but CMs are aware of implications of cost. "One of the problems is that we're actually purchasers of our own provision ... I'm not actually a CN when I'm a CM". Also able to innovate with service use. CM role affected relationship with SS: "the very fact that the person knows you're a purchaser puts it in a very different situation". "I think a CM often becomes an advocate".
	C224	Carer identified CN as having overall responsibility since CM was introduced and the SW bowed out. It means "making sure things were being done".
	Doc	CN as CM evaluation document stated CNs were also "acting as service providers in terms of implementing a nursing programme" but this was clearly spelled out and helped keep role conflict to a minimum. There were times when the CNs felt "vulnerable and isolated, especially negotiating with SS staff".

3.4.11 Pattern-matching (3) case 11 (cont)

Proposition	Source	Evidence from data
5 Practice conflicts	M221	"There are times when the CNs, do explore avenues more in-depth, therefore raising expectations that a service is going to be provided when perhaps there aren't going to be sufficient resources to enable that to happen". "We actually have a quality group within the community nursing service".
	N222	Described large caseload due to taking on 2 colleagues' work and hospital closure. This meant "others have been pushed to the back as being of less priority". Had criteria in place for CN CM based on complex health needs and 4 priority categories. Within CM group "I would say CM has up to date enabled us to provide a better service across the board", which is more needs and user-led, though "there's always going to be people falling through the net".
	C224	Carer described own involvement in negotiating service input. Previous CN CM "did a lot in a short while ... it seemed to come together". But living with uncertainty due to short term funding contracts for care package.
	Doc	CN as CM evaluation documentation described "excellent practice" in quality of work of CNs, but stated that it was time consuming. But it "prevented clients falling through the net". Reported CNs felt "very positive" about CM role.

Pattern-matching (4) case 11

1. Professional issues
There was some ambivalence from both respondents about the suitability of CNs for CM; doubts concerned its novelty, the personalities involved and the need of a professional nurse qualification. On the other hand it was felt to be compatible with the nursing process, keyworking and assessment, its ability to promote nursing autonomy/authority and to formalize much of what nurses do already with certain client groups (±). The CN felt CM was attractive to LD nurses as their role became threatened (✓) but that it may divorce nurses from their professional nursing allegiance (✓).

2. Organizational issues
There appeared to be disagreement about the strategic planning for CM, with the manager talking about months of multidisciplinary discussion and the CN stating that it had not been thought through (±). Similarly, while the manager was involved in various subgroups, the CN talked of a "top-down" method of implementation (±). There was mention of the need to adjust thinking to accommodate the changes initially, though this seemed to be going smoother now (✓). Liaison with SS had traditionally been good, and problems - largely due to personalities - were not insoluble (x).

3. Preparation and support
Interestingly, the CN felt the SS-led training to be more acceptable than the manager did (±), while the supervision arrangements appeared satisfactory to both (x). The potential for conflict with regard to accountability was acknowledged, but was felt to be no problem if personalities gelled (x).

4. Case management model
CM was obviously tied up with related legislation and practice in the LD field, giving rise to some confusion, though the emphasis was on the ability to create innovative care packages. It was seen to be within the purchasing realm (✓), with the budget residing appropriately at team leader level (✓). Care provision was also part

of the remit, and though this was envisaged in the documentation as giving minimal rise to conflict, the CN found that combining the two roles was stressful (±). There was a feeling that SS still held the power in CM, but that this was changing and CNs were gaining acceptance (x). The CN was in favour of an advocacy role for the CM (x).

5. Practice conflicts

There was a fear that inadequate resources would lead to falsely raised expectations (✓), and the CN's large and increasing caseload was also affecting care quality, particularly for the lower priority clients (✓). However, strategies to improve quality included a quality group and targeting, and overall it was felt that services were better, and more user-led, than in other areas (✓).

3.5 The case studies - longitudinal follow-up

Although the responses to the follow-up questionnaire included information from each of the 13 case study sites (section 2.7), these were unevenly distributed according to both number and status of respondent(s):

Table 3.15 Follow-up responses according to status of respondents and number across cases

Case	Specialism	Number of responses		
		Manager	CNs	Total
1	DN	1	1	2
2	CLDN	1	1	2
3	CLDN	1	1	2
4	DN	0	1	1
5	CPN	1	3	4
6	CPN	1	0	1
7	CPN	0	1	1
8a	CPN	1	1	2
8b	CPN	1	1	2
8c	CPN	0	1	1
9	DN	1	2	3
10	CPN	1	2	3
11	CLDN	1	0	1
Total		10	15	25

Key: CLDN community learning disability nursing
CN community nurse
CPN community psychiatric nursing
DN district nursing

There were thus two cases (6 and 11) where responses were from the manager only, four cases (3, 4, 7, 8c) where responses were from one or more community nurses only, and seven cases (1, 2, 5, 8a, 8b, 9, 10) where responses were from the manager and at least one

community nurse. There was one reply only from five cases (4, 6, 7, 8c, 11) and multiple replies (two or more) from the remainder.

The responses to the four structured questions were as follows:

Table 3.16 Follow-up responses to questions by case

Case no.	Specialism	CNs still CMs?	Relative change over 4-5 years	Reasons if discontinued	Anticipated future change
1	DN	N	NA	policy change	unsure
2	CLDN	Y	no change	NA	no change
3	CLDN	Y	increase/no change	NA	decline
4	DN	N	NA	postholder left	no change
5	CPN	Y	increase/no change	NA	expand/ unsure
6	CPN	Y	increase	NA	expand
7	CPN	N	NA	policy change	expand
8a	CPN	Y	increase	NA	expand/no change
8b	CPN	Y	increase	NA	expand/ unsure
8c	CPN	Y	increase	NA	expand
9	DN	Y/N	no change/ decrease	NA/NR	expand/no change/NR
10	CPN	Y	increase/no change	NA	expand/no change
11	CLDN	Y	increase	NA	expand

Key (additional abbreviations):

Y	yes	N	no
NA	not applicable	NR	no response to question

There was a variety of responses to all questions, but nine of the 13 case study sites appeared to have community nurses still in a case manager post. Broken down by specialism these were six of the seven mental health cases and all three learning disability cases, with two district nursing cases replying negatively and one with a mixed response (the manager replied that district nurses had never worked as case managers, while the two community nurses felt they were still working in the role!).

Question two was about the relative change in numbers of community nurse-case managers (for those where they were still employed) over the previous four to five years. The mental health specialism recorded six cases of expansion and one mixed response (two expansionist, two no change). Learning disability responses comprised one statement of expansion, one of no change and one mixed response (expansion/no change). Of the two district nurses who considered themselves in a case management role, one felt numbers had declined and the other that there had been no change.

Question three asked for reasons where there had been a discontinuation of the community nurse-case manager role, with four suggested options given plus an "other" category. Of the three cases responding, two (district nursing and mental health nursing) specified policy changes, with one district nurse enlarging upon this by stating the new policy was for the postholder to now act as liaison nurse to social services. Another district nurse stated that the postholder had left.

Anticipated future change in numbers of community nurse-case managers (question four) also displayed variety, both between and within specialisms and within cases. Once again, the mental health specialism displayed the most optimistic picture, with three cases anticipating future growth, and four mixed replies, these all being a combination of expansion, no change or unsure replies (but no anticipation of decline). District nursing tended to a no-change or unsure position, with learning disability displaying a mixture of expansion, decline and no change.

Fourteen of the 25 replies volunteered additional comments in response to question 5, which may be grouped, as with the questionnaire follow-up comments, according to the influencing variables governing the literature review. Firstly, in terms of national policy, primary care groups were touched on by three respondents in two cases (district nursing case 1 and mental health case 8b). Both appeared to see possibilities for nurses here, through increased joint working and role expansion, though the district nurse manager questioned whether nurses would actually grasp the opportunities this

provided. The "partnership agenda" was also referred to by one (learning disability case 2) manager as a way forward.

Secondly, professional suitability for the case management role was endorsed through a number of issues, including the partnership issue, seen by one (learning disability case 2) respondent as being a philosophy upheld by a large number of nurses. Another learning disability respondent (case 3) felt that the current local way of working within case management led to role clarity without compromising the therapeutic element, while a mental health view (case 8b) was that nurses are suitable case managers since they can cope with higher caseloads and more dependent clients that social workers or occupational therapists (though a separate learning disability opinion, case 2, felt that current nurse workloads were too heavy for the role).

Thirdly, a number of current trust-wide initiatives were mentioned by mental health or learning disability respondents. In three cases (7, 8a, 8b) these appeared to be conducive to CPN case management and included a bid to restore community nurse case management, a joint operational policy with social services and formal recognition by one trust of a need for joint working and managed care. On the negative side, one CPN (case 5) felt funding remained a major hurdle, with a need to increase staff and decrease workloads but with no extra money available. For the learning disability specialism, case 3 mentioned that the local trust was currently looking at a number of options which would re-orientate community nurses within the case management scenario, while a learning disability manager (case 11) wrote of a bid for joint commissioning for funding health-led case management in learning disability practice.

Finally, some impression was given (again from the mental health and learning disability specialisms) of individual initiatives within an area, such as the resumption of CPN case management in case study site 7 as an intensive community support team (ICST), the creation of three specific rehabilitation CPNs in site 8c undertaking case management and the integration of CPN case management with social services in site 8b. The manager from case 11 (learning disability) wrote that

currently there were only four individuals subject to nurse case management in the present system, while in case 3 the CLDN's case file had only three eligible for this.

Overall, the response rate was considered adequate for providing an impression of the durability of community nurse case management over time. Results largely mirrored those of the questionnaire follow-up (section 3.3.7) in that the model of practice appeared to be more suited to mental health and learning disability than to district nursing (though even at the case study level of investigation there remained doubts over the conceptualization of case management within this specialism). However, recent policy initiatives were seen to provide opportunities for role development along case management lines for those district nurses willing to grasp them.

3.6 The case studies - cross-case analysis and discussion

The final stage of pattern-matching comprised a cross-case analysis. Although Yin (1994) did not specifically address particular approaches to this stage separately from case study analysis in general, the emphasis on replication, rather than sampling, logic at the design stage suggests that the practice of analytic generalization, whereby a single case is "matched" with predefined theory or propositions, should be repeated over the total number of cases, the findings of each case contributing to that theory. In order to avoid the potential over-complexity which multiple cases would present with, given the large number of variables involved, it was thought fit to utilize Yin's (1994) concept of rival explanations as patterns, as interpreted in table 3.12. Conclusions thus addressed objectives ii), iii) and iv) of the research (section 2.2) by producing a picture of which particular combination of variables led to effective, appropriate and enduring community nurse case management practice. Finally, the discussion of this stage included a consideration of an emergent theoretical model, constructed from the four levels of contextual variables which threaded through the research, of how community nurses as case managers have interpreted and viewed their practice.

A number of the conditions which made Yin's "rival explanations" strategy appropriate may readily be seen - the research was based on a multiple case study, it sought to uncover "explanations" of what makes effective community nurse case management and no pretest was conducted. Additionally, a tabulation of degrees of support for propositional statements for each case (table 3.17) facilitated a retrospective analysis of variables across all 13 cases, and so enabled the identification of outcome measures with which to match the explanations. Although potentially problematic, as is generally acknowledged to be the case with all nursing research (Roe, 1998b), outcome identification was facilitated by a distinction between structure, process and outcome focused propositons, based on the structure, process and outcome variables (table 3.11) upon which the propositions were drawn. Thus propositions 1A, 1B and 1C could be identified as practitioner-orientated outcomes and 5A, 5B and 5C as practice (quality or client) related outcomes. Additionally, the unsolicited comments on job satisfaction, referred to above (section 3.5) provided a further outcome perspective, while the presence of community nurse case management practice at the five year follow-up provided yet another indicator. Although it may be argued that the research was, in identifying a number of outcome variables, less robust than if it had focused on a single one (as preferred by the "rival explanations" approach) it was also felt that, taken together, these outcomes represented a global picture of appropriate and effective case management, whereas individually, they pointed to only one component of what was being measured.

The starting point for this stage of pattern-matching was a search for the cases which best and least met all the specified outcome measures, that is, supported the positively worded outcome propositions (1A, 1B, 5C), failed to support the negatively worded outcome propositions (1C, 5A, 5B) and also expressed job satisfaction and were still in post at follow-up. These were calculated by allocating a score of 1 for each positive outcome, zero for each negative outcome and 1/2 for partial support or incongruent data. The total scores out of a maximum of eight showed the cases with most favourable outcomes to be cases 8b, (score 6 1/2), 8a (score 5 1/2), 10 (score 5) and 8c (score 5). The lowest scoring cases were 9 (1 1/2), 1 (3), 4 (3) and 7 (3).

Table 3.17 Pattern-matching (5) cross-case analysis

Case	Proposition number																
	1A	1B	1C	2Ai	2Aii	2B	2C	3A	3B	3C	4Ai	4Aii	4Aiii	4B	4C	5A	5B	5C
1	±	✓	✓	✓	±	x	✓	x	x	x	✓	✓	x	✓	✓	✓	✓	±
2	✓	±	✓	✓	±	✓	✓	±	-	-	±	-	✓	-	x	✓	✓	✓
3	±	✓	✓	±	±	±	✓	✓	±	✓	±	✓	✓	x	✓	✓	✓	✓
4	✓	±	✓	x	x	x	✓	±	x	x	x	x	✓	✓	x	✓	✓	✓
5	✓	±	✓	±	±	✓	✓	✓	x	x	±	✓	✓	±	x	✓	✓	✓
6	✓	±	✓	✓	x	✓	±	x	x	x	±	±	x	-	±	✓	✓	✓
7	±	±	x	x	x	✓	x	x	✓	x	✓	✓	✓	✓	x	✓	✓	✓
8a	x	±	x	✓	x	✓	±	✓	x	x	✓	±	x	x	✓	±	±	✓
8b	✓	✓	±	±	x	✓	x	✓	x	±	✓	✓	✓	x	x	±	±	✓
8c	x	x	x	✓	x	✓	x	✓	x	x	x	✓	✓	x	-	✓	x	✓
9	x	x	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	-	x	✓	✓	x
10	✓	✓	✓	x	x	x	x	✓	x	x	✓	✓	±	x	x	✓	✓	✓
11	±	✓	✓	±	±	✓	x	±	x	x	✓	✓	±	x	x	✓	✓	✓

Key: ✓ data support proposition
x data do not support proposition
± data lack congruence
- insufficient data

Such a system is, of course, a very crude tool and any discussion of outcomes must also, in case study research, take into account any underlying explanations of a given (positive or negative) response to a propositional statement. This was addressed in the accompanying discussion.

Having identified the best and worst outcomes, given cases then became representative, in their structural and process variables, of the pattern to be replicated by the remainder of cases in identifying the independent variables of importance for appropriate and effective practice. Analysis was centred mainly on propositional groupings (table 3.14) and included the outcome-related propositions, in view of the extra light to be shed by related respondent comments on the crude scores. It was also considered important to compare outcome scores specifically across community nurse specialisms and case management models, the two variables identified as likely to be of importance in the first questionnaire phase (section 3.3.8) and this was undertaken first.

3.6.1 Community nurse specialisms and case management model

While identification of community nurse specialism, in terms of district nursing (DN), community psychiatric nursing (CPN) and community learning disability nursing (CLDN), has been a feature governing both the literature review and data collection within the research, classification of case management models is less clear-cut. The tripartite definition of Beardshaw and Towell (1990) was found useful as a shorthand device for this, but, not surprisingly, few "pure" models were found to exist in practice, as demonstrated in both the literature and the descriptive case summaries (Appendix VIII). Nevertheless, this categorisation is used in the following tables based on information derived from all descriptors within these summaries; where elements of different models existed within one case, classification was based on where the emphasis appeared to lie, that is, toward brokerage, entrepreneurship (the social services model) or keyworking/care coordinating (see section 1.1.3), though the presence of a strong secondary model influence was noted. Additionally, since in two of the CPN projects, case managers identified so strongly with

the Care Programme Approach (CPA), this was classified as a supplementary model. These two independent variables are collated in table 3.18.

Table 3.18 Cases by specialism and model

Case	1	2	3	4	5	6	7	8a	8b	8c	9	10	11
Spec	DN	LDN	LDN	DN	CPN	CPN	CPN	CPN	CPN	CPN	DN	CPN	LDN
Model	SS	KW/ SS	SS	KW	CPA	CPA/ SS	SS	KW/ SS	KW/ SS	KW	KW	SS	SS

Key: DN= district nursing
LDN = (community) learning disability nursing
CPN = community psychiatric nursing
SS = social services/entrepreneurship model
KW = keyworker/care coordinator model
CPA = Care Programme Aproach
/ = combination of two models (primary model denoted first)

In this classification it is interesting, but perhaps not surprising, to note that there were no examples of the brokerage model, which has been seen to be one largely limited to North America (section 1.1.3). Two of the three district nursing projects adopted a keyworker model, though one of these (case 9) only demonstrated this (and therefore case management) in a limited way. One of the mental health projects also favoured keyworking, with two following the social service practices and two a mixed model (social services/keyworking). In the two identifying with the CPA, it was difficult to isolate perceptions of case management apart from this. Of the learning disability projects, two were based on the social services model and one on keyworking. Regarding the match with outcomes, (see next table) the four cases with the highest scores were CPN-led, with a mix of social services and keyworking models. The three lowest scoring cases were the three DN-led projects, again with two of these working to a keyworking pattern. However, no conclusion can be drawn regarding the "best" model(s) until the more detailed case and model analysis is complete.

3.6.2 Professional issues

Responses to the first group of propositions, related to professional issues, are outlined in table 3.19. Six cases were broadly in

Table 3.19 Comparison of case specialisms, models and outcomes with response to professional issues

Case	Specialism	Model	CN/CM compatibility	Specialism compatibility	Role erosion	Outcome score
1	DN	SS	±	✓	✓	3
2	CLDN	KW/ SS	✓	±	✓	3 1/2
3	CLDN	SS	±	✓	✓	4
4	DN	KW	✓	±	✓	3
5	CPN	CPA	✓	±	✓	4
6	CPN	CPA/ SS	✓	±	✓	4 1/2
7	CPN	SS	±	±	x	3
8a	CPN	KW/ SS	x	±	x	5 1/2
8b	CPN	KW/ SS	±	✓	±	6 1/2
8c	CPN	KW	x	x	x	5
9	DN	KW	x	x	✓	1 1/2
10	CPN	SS	✓	✓	✓	5
11	CLDN	SS	±	✓	✓	4

Additional key: ✓= data support proposition; x = data do not support proposition; ± = data lack congruence; Y = yes; N = no

agreement that there is a similarity between the disciplines of case management and community nursing (proposition 1A), with three indicating disagreement and four equivocal. Of those in agreement,

only one of which was based on the social services model, specific reasons given by both the CLDN and DN projects (cases 2 and 4) included the importance of assessment to both nursing and case management in their keyworking model. The four CPN projects responding positively (cases 5, 6, 8b, 10) emphasized the continuity aspect, seeing case management as an extension to their role and training. Reasons for disagreement included a questioning of the need for any professional qualification for the case manager role (CPN cases 8a and 8c) and a need for community nursing to be more adaptable (CPN case 7) in order to subsume case management practices. Of particular significance is the importance ascribed to individual personalities, rather than to disciplinary background, in gauging suitability for the case management role (CLDN case 11 and DN cases 1 and 4).

In terms of their own specialism (proposition 1B), five of the 13 cases generally supported compatibility with case management, with six expressing answers lacking agreement and two disagreeing. Surprisingly, perhaps, these responses tended not to correspond with those given to the first proposition, about community nursing in general. Further, more positive statements, representing all specialisms, were associated with the adoption of the social service, rather than the keyworker, model. It may be that respondents, and in particular the practitioners, found it easier to think in terms of their own practices when considering the case management role, rather than addressing its application more abstractly to nursing in general. However, the anomaly may also be at least partially explained by looking at the reasons behind the responses.

Those giving positive replies appeared to endorse professional role development for their specialism in terms of the promotion of specialist skills (DN case 1, CPN case 6, CPN case 8b), role extension (CLDN case 3), adaptability (CPN case 8a) and widening boundaries (CPN case 7). They also displayed an affinity with social care practices, as might be implied by the adoption of the social services model of case management. For example, CPN case 10 emphasized the appropriation of both medical and social models by mental health practitioners, while at least three cases not primarily classified as

working to a social service model (CPN cases 6, 8a, 8b) indicated secondary elements of this framework. These comments contrast strongly with those not supporting the proposition. In general these were less well articulated, simply asserting that case management and a given nursing specialism were "different", or respondents were themselves less happy or enthusiastic about the idea. One DN (case 9) expressed a wish to return to a traditional DN role, which precluded extension into case management practices as generally understood.

The contrast between the "adaptors" and the "traditionalists" was, to some extent, also evident in the issue of role erosion (proposition 1C). Although only three cases disagreed with the proposition, or simply did not talk in these terms, (that is, expressed no fears of role erosion) and only one presented with mixed responses, these were all CPN cases (7, 8a, 8b, 8c) which had taken a largely ambivalent attitude toward community nurse/case management compatibility. However, on analysis of supporting comments, it appears that these "adaptors" had assumed a somewhat extreme position, whereby they now felt distanced from their profession of origin. With a greater allegiance to case management than to nursing, they felt no threat to their professionalism. This was overtly stated in interview details from cases 8a and 8c, and implicit in interview details from cases 7 and 8b.

A number of the remaining case respondents, on the other hand, while speaking in terms of uncertainty, loss of status, vulnerability, professional marginalization and fear of encroachment from other professionals, had also seen a potential role for their specialism as case managers; although this "niche" was sometimes put forward for negative reasons (for example CLDN case 11 felt that case management to be an attractive new direction at a time when that specialism was being threatened) it also often accompanied a desire to move forward and capitalize on specialist skills (for example DN case 1, CLDN case 3, CPN case 6, where respondents talked about overcoming difficulties, about role extension and about promoting specialist assessment).

Thus it appears that, in the context of the opportunities and challenges presented by case management to specialist professional roles, two

"ideal types" may be identified. On the one hand existed the "adaptors", characterized by a confidence in their role and an associated tendency to identify with case management itself as much as, if not more than, nursing; on the other hand were the "traditionalists", characterized by uncertainties and fear of role erosion, and inclined to adhere to traditional nursing values, rather than explore new potentials. In practice, most of the case examples were situated somewhere along the continuum between these two extremes, adopting a "mediation" role, in varying degrees; the existence of the "traditionalist" stance of DN case 9 is, perhaps, a more surprising finding than the "adapting" examples outlined above, given that the research actively sought out practising case managers. However, it has been demonstrated that this particular case embraced a limited keyworker model more akin to community nursing than to case management and this, perhaps, serves as an example of a "type" which may be more frequently found in the general population. A schema of these "types", with case classification, is depicted in fig. 3.1.

Fig. 3.1 Ideal types of community nurse case managers

"Adaptors"	"Mediators"	"Traditionalists"
• confident in role	• potential for marginalization but this can be overcome	• uncertain in role
• identifies with case management	• sees case management as extension of community nursing	• identifies with nursing
• takes on new roles	• specializes within profession	• adheres to traditional roles
• cases 7, 8a, 8c	• cases 1,2,3,4,5,6,8b,10,11	• case 9

An interesting point to emerge from the analysis of this propositional group is that, though concerned with specific outcome variables, there is little correlation between these and overall outcome score. For example, the "adaptor" group contained both the lower scoring outcome case 7 and the higher scoring outcome cases 8a and 8c. This indicates a need to further develop the theoretical model through the remaining propositional groupings in order to explore more fully the features of successful community nurse case management. However, at the current stage of analysis it appears that appropriate and effective

community nurse case management, in terms of professional issues as identified in this research, occurred where community nurses adopted a social services-type model of working, or one which displays elements of this model. For DNs it also occurred where they were able to become more adaptable in their practices, rather than retreat into a tendency to "traditionalism", and for CPNs where they were able to take their professional skills with them, rather than succumb to the danger which accompanied their practice of losing entirely their professional identity.

3.6.3 Organizational issues

Responses to the second group of propositions, related to organizational issues, are outlined in table 3.20. There was a mixed response to proposition 2Ai, though the number of cases supporting the literature, or providing equivocal answers, was greater than those answering to the contrary. In other words, there was little evidence of all-level organizational involvement in the strategic planning for case management. Interestingly, this variety was reflected in both the "best outcome" cases and the "worst outcome" cases and, in addition, no generalization to theory can be made across specialisms or models. This raises the question of the importance of this type of vertical integration to successful case management and, again, further explanations must be sought in the separate case respondents' comments. Those from the "best outcome" cases suggest vertical integration was seen as less important than horizontal integration. For example, for respondents from case 8b the piecemeal approach to planning was seen in a positive light, since it allowed the freedom to develop local initiatives which central policy hindered. The lack of success in case 8a with integrated planning in a context where the impetus came largely from the community care legislation, reinforces the same point, while successful integration in case 10 focused on the level of the manager, who was involved in local working groups. On the other hand the "poor outcome" case 9 linked failure here to a lack of collaboration horizontally with social services, the lead agency in community care.

Table 3.20 Comparison of cases by specialism, model and outcome with response to organizational issues

Case	Specialism	Model	Organizat'l integration	Nurse involvem't	Change & stress	Interagency collab'n	Outcome score
1	DN	SS	✓	±	x	✓	3
2	CLDN	KW/ SS	✓	±	✓	✓	3 1/2
3	CLDN	SS	±	±	±	✓	4
4	DN	KW	x	x	x	✓	3
5	CPN	CPA	±	±	✓	✓	4
6	CPN	CPA/ SS	✓	x	✓	±	4 1/2
7	CPN	SS	x	x	✓	x	3
8a	CPN	KW/ SS	✓	x	✓	±	5 1/2
8b	CPN	KW/ SS	±	x	✓	x	6 1/2
8c	CPN	KW	✓	x	✓	x	5
9	DN	KW	✓	✓	✓	✓	1 1/2
10	CPN	SS	x	x	x	x	5
11	CLDN	SS	±	±	✓	x	4

In the responses to proposition 2Aii, seven cases failed to support the view from the literature that nurses were rarely involved in the implementation of case management, while five were equivocal. Significantly, the only case expressing agreement with the proposition was case 9, which had shown the "worst outcome" score and where initial involvement appeared to have been relinquished. The four "best outcome" cases all demonstrated feelings of involvement in planning and implementation in phrases such as "a bottom-up approach", while equivocal cases tended to demonstrate a lack of congruence between managers, who perceived themselves to be involved, and community nurses, who did not (cases 1,2,3,5,11).

There was an overwhelming feeling in nine cases, in response to proposition 2B, that change was detrimental to practice, giving rise to stress and anxiety. However, surprisingly, perhaps, three of the four "best outcome" cases showed agreement with this proposition, while two of the four "worst outcome" cases disagreed. One explanation for this, made explicit in case 10, might be that the negative effects of change were compensated for by the involvement of nurses in the implementation process previously noted, since this would imply a certain degee of control within an otherwise hostile context. This theory also supports Lipsky's (1980) concept of street level bureaucracy, whereby practitioners are said to be able to exercise a certain amount of discretion within overall policy demands.

Proposition 2C, which was about interagency collaboration, again attracted a variety of responses, though overall a less unexpected pattern emerged, with the best outcome cases displaying lack of support for the proposition (that is, demonstrating good interagency working) and the worst outcome cases displaying support (that is, poor interagency working). This is, therefore, likely to be a crucial ingredient of effective and appropriate community nurse case management. Other points of interest emerging in comparing responses across cases included the observation that variability was according to specialism, with the three district nurse cases (1, 4, 10) exhibiting less successful interagency relations than the CPN cases, four of which were successful and three partially successful. Comments by respondents largely supported the emerging theory that the lower, or "street" level organizational elements were more important than the higher management and policy ones. For example, a respondent from case 8b commented that good relations were maintained largely by ignoring government guidelines, while several cases (1,4,11) stressed the importance of individual personalities to this; several others (cases 3,4,6,8a) noted better interagency working at practitioner than at managerial level. A final point relates to communication skills, with the poor outcome case 9 demonstrating little communication and superficial joint working, compared with evidence of actively working to overcome this in cases 5,10 and 11.

Overall in this propositional group a partial pattern can be seen to exist in terms of degrees of the major elements (horizontal and vertical integration and practitioner involvement) which were present on analysis (fig. 3.2). "Best" cases tended to cluster around an area demonstrating good horizontal integration and practitioner involvement, with or without vertical integration (the upper middle group of cells in the figure). However, theoretical replication can only be said to have occurred if the "worst" cases followed a different pattern to this, and it may be noted upon "eyeballing" the figure that case 7 did not conform to this expectation, since it demonstrated the same characteristics as case 10. Therefore it must be concluded that this amended propositional pattern may be a necessary, but not sufficient, position for effective community nurse case management. In order to discover other possible conditions, the remaining propositional groupings need to be analyzed.

3.6.4 Preparation and support

Features related to issues of preparation and support are illustrated in table 3.21. In responding to questioning about preparation for the case management role, (proposition 3A) seven of the 13 cases indicated poor preparation, three produced mixed answers and three reported good preparation. Two of the latter (one DN and two CPN cases) were in the "poor outcome" group, which, on the face of it, seems surprising, but, again, an analysis of individual responses and of the research method may offer possible explanations for this. It must be remembered that the research was seeking respondents' views on particular issues, so no absolutes may be guaranteed, and it may be that those reporting good preparation had lower expectations than those reporting otherwise. One reason for suggesting this is the fact that in three of the "best" cases (8b, 8c, 10) practitioners were studying for either bachelors or masters degrees, yet criticized the lack of education for case management. On the other hand, none of the "poor" cases were studying at this level, yet they appeared more satisfied with case management training. Another possible explanation is that adequacy of preparation was linked to the issue of supervision and support, becoming less important where this support was good. This suggestion therefore needs to be tested out.

Fig. 3.2 Organizational issues: degrees of practitioner involvement in planning/implementation of case management and of horizontal (interagency) and vertical (managerial) integration.

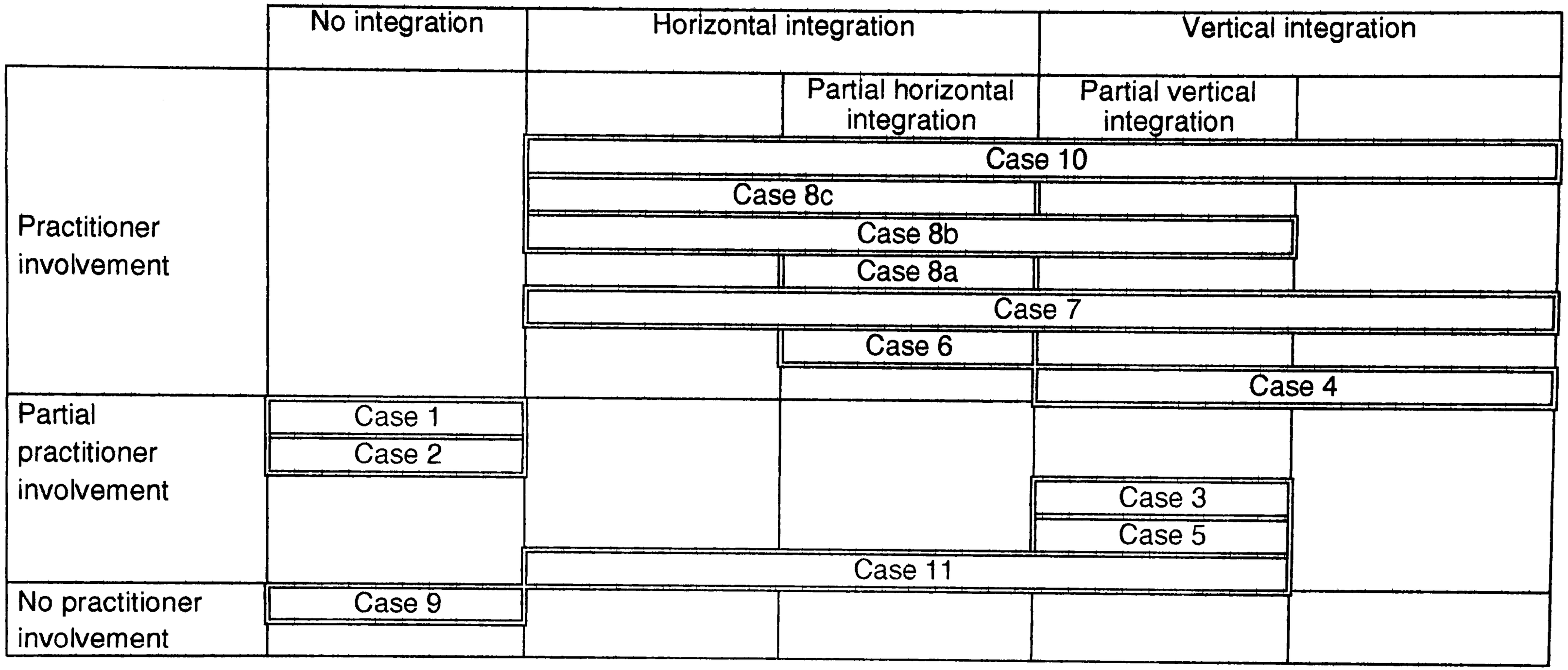


Table 3.21 Comparison of case specialisms, models and outcomes with response to preparation and support issues

Case	Specialism	Model	Preparation	Support	Accountability	Outcome score
1	DN	SS	x	x	x	3
2	CLDN	KW/ SS	±	-	-	3 1/2
3	CLDN	SS	✓	±	✓	4
4	DN	KW	±	x	x	3
5	CPN	CPA	✓	x	x	4
6	CPN	CPA/ SS	x	x	x	4 1/2
7	CPN	SS	x	✓	x	3
8a	CPN	KW/ SS	✓	x	x	5 1/2
8b	CPN	KW/ SS	✓	x	±	6 1/2
8c	CPN	KW	✓	x	x	5
9	DN	KW	✓	✓	✓	1 1/2
10	CPN	SS	✓	x	x	5
11	CLDN	SS	±	x	x	4

Additional key: - = incomplete data

Overall, nine cases felt that there was good support for the case manager role, in contrast to the literature, with two (both "poor outcome" cases) feeling it was poor, one with a mixed response, and one case producing no data on this issue (proposition 3B). Generally, therefore, it may be said that professional support was seen as an important part of community nurse case management, especially to the "good outcome" group, so this, indeed, may have compensated for the poor preparation, as suggested. A further point to note with this

proposition is that case 7, which appeared to fulfil the conditions for good case management in the last grouping, here reported poor support, thus not continuing to match the expected pattern if this were indeed a "model" case, in terms of independent variables.

Finally in this group, the issue of accountability (proposition 3C) produced a similar response which contrasted with the literature, since nine cases experienced no major problems with the concept in practice. The two cases which experienced problems included the lowest scoring outcome case 9, while the one with a mixed response was the "model" case 8b. Again one case produced inadequate data regarding the proposition. On the face of it, this pattern of responses is surprising, since the "best" and "worst" outcome cases appear to share, at least in part, some divergence from the general trend. However, an examination of the comments which underpinned the classification illustrates the difficulties of analysis, and the often misleading ways such classification may be constructed. Thus case 8b was classified as a mixed response to the literature, since, while the community nurse saw no conflict in his accountability, the manager saw a need to work through the issue, in the same way as case 3 responses (classified as agreeing with the literature) saw it as a complex issue. Both of these could be described as a positive awareness of the issues in the same way as did case 11's attitude to potential conflict (no problem so long as personalities gelled). On the other hand, classification of case 9 was of a different order, with no positive note to the description of the problematical nature of diffused accountability.

Fig. 3.3 provides a visual representation of the variation in response to preparation, support and accountability issues, which largely conforms to the expected pattern; all the "high outcome scoring" cases appear clustered together in the upper right cell, while all "low scorers" appear elsewhere (though in no definite pattern). It should be noted that case 7, a low scorer which appeared to "match" the characteristics for organizational features of the high scorers, does not share here those for preparation and support. On the other hand, case 5, (medium scorer) which here shares the pattern of the high scorers for preparation and support, fell outside the expected match for good

Fig. 3.3 Variation in adequacy of preparation, support and accountability issues across cases

	Good preparation	Mixed response	Poor preparation
Good support	✓1 ✓6	✓4 ✓11	✓5 ✓8a ±8b ✓8c ✓10
Mixed response			X3
Poor support	✓7		X9

Key:

1-11 Case numbers

✓ No accountability problems

X Accountability problems

± Mixed response to issue

(Missing data on case 2)

organizational features. The cumulative expected pattern thus far for effective community nurse case management stipulates the most important need to be for nurses to be either "adaptors" or "mediators", for cases to demonstrate good horizontal integration and practitioner involvement, and for good support mechanisms to be in place, with a clear and positive approach to accountability.

3.6.5 Case management model

This group of propositions focused in greater detail on the model of case management adopted in the case study projects, together with related issues concerning official recognition of the case manager role and the approach to advocacy. Cross-case responses are given in table 3.22.

Table 3.22 Comparison of case specialisms, models and outcomes with response to case management model issues.

Case	Specialism	Model	Purch'r	Budget devol'n	Provid'r	Recognit probs	Advoc't probs	Outcome score
1	DN	SS	✓	✓	x	✓	✓	3
2	CLDN	KW/ SS	±	-	✓	-	x	3½
3	CLDN	SS	±	✓	✓	x	✓	4
4	DN	KW	x	x	✓	✓	x	3
5	CPN	CPA	±	✓	✓	±	x	4
6	CPN	CPA/ SS	±	±	x	-	±	4½
7	CPN	SS	✓	✓	✓	✓	x	3
8a	CPN	KW/ SS	✓	±	x	x	✓	5½
8b	CPN	KW/ SS	✓	✓	✓	x	x	6½
8c	CPN	KW	x	✓	✓	x	-	5
9	DN	KW	x	✓	✓	-	x	1½
10	CPN	SS	✓	✓	±	x	x	5
11	CLDN	SS	✓	✓	±	x	x	4

In response to proposition 4Ai, six cases unequivocally claimed to have purchasing responsibilities and four gave mixed responses in the form of the different interpretations of case management held by community nurses and their managers; in cases 2 and 3 the manager emphasized the purchasing element and the practitioners the clinical element, while in case 5 there appeared to be confusion between the terms "case manager" and "care coordinator", the manager describing only the latter in terms of a care delivery function. Surprisingly, perhaps, in case 6 it was the community nurse, rather than the manager, who described case management as being financially driven. The three cases not involved in purchasing were all "low outcome"

scorers. Case 8c was actually defined in terms of a brokerage, as opposed to a purchaser, function, which is unusual in the UK, though the involvement in the provider side casts doubt on the existence of a pure brokerage function.

Agreement with proposition 4Aii indicated a certain degree of budgetary devolution, as occurred in the majority of the literature describing successful case management. However, because of the wording, disagreement could designate either full devolution (to case manager level), or agreement with this on the one hand, or lack of any devolution on the other. Thus it is not surprising to find support for the proposition among both those claiming a purchaser model (cases 1,7,8b,10,11) and those with no purchasing responsibility (cases 8c, 9), as well as those with a mixed response (cases 3,5). Reasons for support were, as might be expected in the light of this, quite different. For example, in a number of these cases the budget was devolved to team manager/leader level (1,3,8c,9,10,11). However, while in some cases this meant that the community nurse had access (cases 1,10), in at least one case (9), practitioners were not involved. Further, while in some cases respondents considered this level appropriate (8c, 11), in others this led to problems (3). Again, in some the team leader was from a social services base (1) and in others from a nursing base (9). In other cases classified as supporting the proposition, respondents appeared to have been talking about their attitude to full devolution (for example case 5), rather than referring to actual practice, while among those giving a mixed response, either the manager (case 6) or community nurse (case 8a) did not support full devolution and other case respondents did; this, again, meant "attitude" responses were classified on a par with actual practices. Finally, of the three cases reporting no devolution, only one (case 4) was classified as not supporting the proposition, since this situation was felt to be appropriate practice (case 7 respondents reported a pro-devolution attitude in a non-devolution structure, while case 8a reported a mixed response to the same). In relation to outcomes, there was a tendency for high scorers to partial budgetary devolution, with practitioners having access to the budget (that is, support for the proposition). The exception was case 8a, though even here some devolution was anticipated. Of the "low-scorers", case 9 also showed support for the

proposition on the face of it, but nurses were not involved in financial matters. Cases 4 and 7 reported no devolution, leaving only case 1 following the pattern of the high scorers here.

Responses to proposition 4Aiii were similarly difficult to analyze, as this, too was about both actual practice (that is, provider work) and attitudes (that is, whether it was thought to be appropriate). Eight cases were classified as expressing support for the proposition, however these, as with the non-supporting and mixed responses, were found among both high and low scoring cases, so, once again, possible reasons for this must be sought, both in the explanations provided and in the overall pattern of responses within a case of which the propositional response formed a part. To the community nurse in the "model" case 8b care provision was integral to the specialist work undertaken (relapse prevention in those with enduring mental health problems), which had been an important feature noted in the expression of suitability for the case management role and as a counter to the potential problem of role erosion (propositions 1B and 1C). It also seemed to underpin the need to go against the centralist tendencies of government guidelines in terms of local planning and interagency collaboration (propositions 2Ai, 2C).

In contrast, in case 8a, the second highest outcome scorer, there was little provider work and case management was conceptualized in managerial/ purchasing terms. However, this was also the case where the CPN case manager felt distanced from nursing (proposition 1A, 1B, 1C) but, interestingly, was considering moving back to a therapeutic/community nurse role, with the manager taking over the case management. This element of local negotiation over role definition suggests, as with case 8b, that discretion at the project and personal level is likely to be as important as adhering rigidly to government guidelines in providing "good" outcomes. Other constant features with these two cases - and with the other two higher scoring cases previously cited (8c, 10) - were the involvement of nurses in the planning process (proposition 2Aii), good interagency/horizontal collaboration (proposition 2C) and adequate professional support (proposition 3B), leading to clear accountability within the chosen

role. These features would seem to be more critical than the choice of case management model within the purchaser/provider framework.

Another feature which strongly distinguishes these "good outcome" cases from the low scoring ones is the degree of recognition for the nurse in the case manager role (proposition 4B). Cases 8a, 8b, 8c and 10 all disagreed with the proposition and the literature that acceptance of community nurse case managers by other professionals was not forthcoming, in contrast to cases 1, 4 and 7, where there was general support for the proposition (data for case 9 was missing, possibly due to it being a "non-issue" in a practice model which hardly differed from traditional district nursing). Because of the good correlation with outcome scoring, recognition is likely to be another feature which is a crucial determinant of successful community nurse case management, and it may, therefore, be useful to consider some of the (unsolicited) comments on why the issue was less problematical in certain cases. For example, in case 10 it was felt that problems were avoided due to the assertive approach of the manager, suggesting the importance of actively making the nursing presence felt, rather than adopting a passive approach to role development. In case 11 the power base in community care was originally in the hands of social services, however, purchasing responsibility had put nurses on an equal footing and earned them greater recognition.

The final proposition in this group, relating to the case management model, concerns the role of advocacy, a prominent feature of the "brokerage" model of case management (Beardshaw and Towell, 1990) but also an issue much debated in the nursing literature (section 1.4). The number of cases agreeing that advocacy was problematical or inappropriate was small (3) and included a high and low scoring case, different models in terms of the purchaser/provider emphasis and all three specialisms. Therefore no consensus may be drawn from the proposition, particularly since the proposition wording, like that in proposition 4Aii, included some ambiguity. In particular, since no theory of advocacy was specified, it may be that respondents were replying with different concepts in mind. However, those cases expressing reservations about the advocacy role for case management all focused on the potential for conflict with a purchaser or provider

element, and this must be borne in mind in any consideration of this feature of practice.

This proposition group, based on the case management model, is both large and wide ranging, however, the key differential features which marked out the better outcome cases from the others appear to be less about model *per se*, than about the two dimensions depicted in table 3.23, that is, recognition/validation provided externally by other

Table 3.23 Comparison of external recognition for, and internal motivation within, highest and lowest scoring outcome cases

Case No.	Evidence of external recognition		Evidence of internal motivation	
1	x	Lack of acceptance from SWs.	✓	Development of specialist skills within practice. Personalities important.
4	x	CNs not formally recognized in CM role.	✓	Change predated community care. Personalities important
7	x	Problems of acceptance by others.	x	Change outside CNs' control.
9	-	No data	x	Social services lead agency - nursing involvement relinquished.
8a	✓	No problems.	✓	CN working out model with manager - interchange of roles.
8b	✓	No problems.	✓	Developing specialist work.
8c	✓	No problems.	✓	Model chosen with CN involvement.
10	✓	Problems overcome.	✓	Assertiveness of manager made nursing influence felt.

Key: x Feature not present
✓ Feature present
- Data missing

partnership agencies for the community nurse-case manager role, and the internally motivated effort and discretion to make community nurse-case management relevant within a given local context. This (albeit simplified) classification demonstrates a pattern when represented in a visual comparison between the four highest and four

lowest outcomes scoring cases; the former (cases 8a, 8b, 8c, 10) may be seen to demonstrate both these dimensions, while the latter have one or both of these absent. These characteristics may, therefore, be added to the picture of successful and appropriate community nurse case management found in the case studies, leaving the picture to be completed only by the final propositional grouping.

3.6.6 Practice issues

The last group (5) of propositions concerned practice issues found to be recurrent themes in both the literature and, subsequently, in interviews, supplemented by unsolicited expressions of satisfaction or dissatisfaction. These features, as detailed above, constituted the practice-based outcome propositions already built into the analysis at a superficial level. However, like the practitioner-based outcomes (propositions 1A, 1B, 1C), these have been subjected to more detailed analysis in the light of interviewees' qualitative comments, in order to give a more comprehensive explanatory picture. The immediate impression given from "eyeballing" (table 3.24) is a pattern of general agreement with the propositions and, in view of this lesser degree of variability, the propositions will be discussed in two groups - resources and workload issues on the one hand and coping strategies and satisfaction with work on the other.

Of the 13 cases, 11 supported the literature and the proposition that resources were inadequate for effective case management, and 10 (largely the same cases) that high workloads made practice difficult and adversely affected the quality of care. Two cases (8a, 8b) provided mixed responses, and only 8c disagreed that workloads were prohibitive. Specific resource issues mentioned included the lack of community services to purchase (cases 3, 6), lack of time and/or staff (cases 8a, 8b, 10) and failure to continue funding after the project ended (case 7, the RDP research initiative). Workload issues included high or increasing caseloads (cases 7, 8a, 8b, 9, 10), few discharges (cases 2, 5) and the amount of paperwork (cases 5, 7). The reason for the different pattern in case 8c appeared to lie in the fact that there were no large hospitals in the area to be affected by the community care policy of closures, which tended to swell caseloads in other

Table 3.24 Comparison of case specialisms, models and outcomes with response to practice conflict issues

Case	Specialism	Model	Resources	Workload	Coping strategies	Satisfaction	Outcome score
1	DN	SS	✓	✓	±	✓	3
2	CLDN	KW/ SS	✓	✓	✓	x	3 1/2
3	CLDN	SS	✓	✓	✓	±	4
4	DN	KW	✓	✓	✓	x	3
5	CPN	CPA	✓	✓	✓	±	4
6	CPN	CPA/ SS	✓	✓	✓	✓	4 1/2
7	CPN	SS	✓	✓	✓	x	3
8a	CPN	KW/ SS	±	±	✓	✓	5 1/2
8b	CPN	KW/ SS	±	±	✓	✓	6 1/2
8c	CPN	KW	✓	x	✓	✓	5
9	DN	KW	✓	✓	x	✓	1 1/2
10	CPN	SS	✓	✓	✓	✓	5
11	CLDN	SS	✓	✓	✓	±	4

project areas. Resources and workload issues also had a less obviously agreed link with quality of care in cases 8a and 8c. For example, in 8a, although there was agreement about lack of time and resources, this was not felt to be impinging on care, while in 8b, quality was an issue more directly attributable to the model of case management, at least according to the manager. Further, in 8a, despite a relatively high caseload, the community nurse noted that new referrals had tailed off, so stabilizing the situation, while in 8b, though (again) the community nurse talked about the high caseload, the manager emphasized the ability to provide a needs-led service,

though, admittedly, this was becoming more difficult to maintain in the face of pressure to meet contractual demands. Overall there was almost unanimous agreement that lack of resources and a heavy workload were negative practice issues. There was little to differentiate the better and worse outcome cases with the possible exception of the way these issues were directly linked to practice quality. It is interesting, too, to note that in the only case site not to find workload a problem, this was due to the local context, meaning it was less affected by one of the major community care policy issues.

Proposition 5c, concerning strategies for coping within a context of under-resourcing and overwork, also attracted an overwhelmingly supportive response, though it should be noted that the proposition only emerged from unsolicited comments, and was not, therefore, an explicit issue at interview. There was also a variety of strategies in evidence, although frequently cited ones included targeting, prioritizing or use of referral criteria (cases 2, 5, 6, 7, 8a, 8c, 10, 11), documenting unmet needs for future resource planning (cases 3, 4, 5, 6, 7, 10) and involving users and carers (cases 7, 8b, 8c, 10, 11). Other strategies included differentiating "needs" and "wants" (case 1), implementing grade/skill mix (cases 5, 6), specializing (cases 6, 8b) and imaginative accessing of resources and service providers (cases 8a, 8c). Case 9, the exception to the pattern with proposition 5c, and the lowest outcome scoring case, explicitly mentioned the lack of prioritization, the reluctance to turn down any referrals and the "handing over" to social services departments when it was felt that needs could not be met. This is thus an example of theoretical replication.

Although there was little variation in terms of coping mechanisms, the issue of job satisfaction did appear to discriminate between cases and, therefore, taken with other such features, is likely to be of some importance to good community nurse case management. However, because (like the previous proposition) information was volunteered during the course of an interview, rather than being given in response to questioning, findings must be treated with a certain degree of caution, though, interestingly, a relatively large number (cases 3, 5, 6, 7, 8a, 8b, 9) referred to the actual term "job/work satisfaction" or

"dissatisfaction", while others used synonymous terms such as "rewarding" (case1). "belittled", "put down" and "confused" (case 2), "lost control" (case 4), "feel good about" (case 8c), "happy with that" (case 10), "unhappy about process" but "sold on it in terms of theory" (case 11). Using this classification, case managers in the four best outcome cases demonstrated job satisfaction, while only two of the four poor outcome cases did so. Although the district nurse in case 9 (lowest scorer) appeared satisfied, there is reason, based on previous analysis, to suggest this referred more to the traditional district nursing role, than to the nurse in the case management role. Further, if seen in conjuncion with the analysis of "coping strategies", it may be seen that in this less successful group, response to either one or other of these last two issues demonstrated a less than wholly positive picture; even the apparent job satisfaction of the district nurse in case 1 and the expression of needs being met must be seen alongside the manager's negative opinion on this. This was the same manager who took a very individualistic approach to case management, referring more than once to the importance of personalities and "getting the right person for the job"(propositions 1A and 2C). The point made is not without merit or support (for example, the discussions on the theories of Lipsky [1980] and Trnobranski [1995] in section 1.3 and data from other cases: 4, 8a, 11) and the fact that this case did appear to have the "right person" as case manager only serves to highlight the negative influence of other contextual variables - lack of integration at the local level, lack of recognition by, and collaboration with, other professional agencies, lack of resources and high workload.

Overall findings from the final group of propositions suggest that negative local contextual influences may be less important to community nurse case management than the local and personal responses to these. The "best" cases all demonstrated positive reactions to coping strategies and job satisfaction, despite adverse conditions related to resources and workload, compared to a more mixed profile - often with reverse responses - in the lowest scoring cases. A simplified representation (fig. 3.4) once again highlights a clustering of better outcome cases within two of the nine cells within the grid. The shared features of cases 6 and 10 should not necessarily be considered surprising in the light of previous proposition analysis,

Fig. 3.4 Variation in response to resource and workload issues across cases

		Resource/workload pressure		
		Problem	Mixed response	No problem
Responses and attitudes to pressures	Negative			
	Mixed	1 2 3 4 5 7 9 11		
	Positive	6 10	8a 8b 8c	

Key: [n] = case number

which differentiated, to varying degrees, these two cases (organizational issues, preparation and support, case management model). The completion with this group of the cross-case analysis allows an overall impression to be gained of what constitutes effective and appropriate community nurses case management and what conditions appear to be a prerequisite for this. Before this is discussed further, it may be useful to place the findings within the context of the longitudinal survival of the projects, as outlined in section 3.5.

3.6.7 Longitudinal survival of case management projects

Identification of the "durability" of case management as a model for community nursing constituted one of the original research objectives (section 2.2). It was therefore felt that a reanalysis of the cross-case longitudinal follow-up questionnaire results in the light of the overall findings thus far would be appropriate at this stage to further inform this objective and findings are summarized in table 3.25.

Table 3.25 Comparison of case specialisms, models and outcomes with response to follow-up questionnaire

Case	Specialism	Model	CNs still CMs?	Change profile	Anticipated future change	Outcome score
1	DN	SS	x	NA	?	3
2	CLDN	KW/ SS	✓	→	→	3 1/2
3	CLDN	SS	✓	↑/→	↓	4
4	DN	KW	x	N/A	→	3
5	CPN	CPA	✓	↑/→	↑/?	4
6	CPN	CPA/ SS	✓	↑	↑	4 1/2
7	CPN	SS	x	N/A	↑	3
8a	CPN	KW/ SS	✓	↑	↑/→	5 1/2
8b	CPN	KW/ SS	✓	↑	↑/?	6 1/2
8c	CPN	KW	✓	↑	↑	5
9	DN	KW	✓/x	→/↓	↑/→	1 1/2
10	CPN	SS	✓	↑/→	↑/→	5
11	CLDN	SS	✓	↑	↑	4

Key: ✓ = still in post
x = no longer in post
↑ = increase
→ = no change
↓ = decrease
? = unsure
N/A = not applicable

The response to whether community nurse case managers were still in post constituted part of the outcome score, so it was no surprise to find positive answers in the higher scoring cases (8a, 8b, 8c, 10) and not in

three of the four lower scoring ones (1, 4, 7), with case 9 giving a mixed response indicating lack of agreement that district nurses had ever worked as case managers. However, since responses further indicated that the remaining intermediate scoring cases also continued to employ community nurse case managers, a comparative analysis of change profiles over all cases (not used as part of the outcome score) was considered useful to further explain patterns of degree of success and also to reduce the possibility of a charge of tautological reasoning.

Looking at responses to the question of relative change over the last four to five years, three of the four highest scoring cases showed an increase in the numbers of community nurse case managers, however in the fourth (case 10) respondents depicted a mixed "increase/no change" profile, a pattern shared by three of the intermediate scorers, with a further two suggesting an increase. Therefore, there was little to differentiate the "model" cases here. In terms of future change, there was at least some expression of anticipated expansion in all the highest scorers, but this, too was shared by both intermediate cases (5, 6, 11) and lowest cases (7 and 9). Only one case (3) anticipated a decline in community nurse case management practice. Examination of supporting voluntary comments (section 3.5) showed that five of the nine cases (7, 8a, 8b, 8c, 11) within this category mentioned local initiatives which appeared to facilitate this and were, therefore, considered to be of some importance. This, as previously noted, was particularly so with mental health projects, even taking into consideration their relatively larger representation within the research sample. The three district nurse cases, it will be recalled, tended to look to national policy changes (principally the emergence of primary care groups) for facilitating role development.

3.6.8 Summary

Cross-case analysis, using Yin's (1994) concept of rival explanations as patterns, addressed objectives ii), iii) and iv) of the research, seeking to link particular independent variables with effective outcomes in community nurse case management, based on the practitioner or practice based propositions identified earlier. It also sought to integrate both qualitative data, gleaned from respondents'

comments, and longitudinal data, in order to help "explain" these links.

- The four cases with the highest outcome scores were CPN led, while the lowest scoring cases were DN led. There was a mix of keyworker and SSD-type models of case management, with no examples of pure brokerage.

- Case respondents supporting compatibility between case management and their own specialism tended to adopt a SSD-type model, and be willing to adapt and extend their practice, sometimes to the extent of distancing themselves from their nursing identity. High outcome scores were distributed across both this "adapting" group and the less extreme "mediator" group, as opposed to the less flexible "traditionalists".

- Although there was little evidence across cases of community nurse involvement in organizational planning (vertical integration), high scoring cases (especially CPN based) demonstrated more effective "horizontal" (cross-agency) integration than others. A degree of individual and "street level" control appeared to compensate for the negative effects of stress, which was a universal feature.

- Specific preparation for the case management role was varied and appeared less important than good professional support, though individually-tailored continuing professional and educational development was valued. An awareness of complex accountability issues was also a feature of high scoring cases.

- "Best" cases tended to emphasize purchasing responsibilities, with at least some degree of budgetary devolution and practitioner access to budgets. However, provider work was also seen as important where a nursing specialism had been developed, though there were mixed feelings regarding the importance of advocacy. Particularly valued features were flexibility at the local and individual level in role development and recognition by other professional groupings.

- There was agreement across cases that resources were inadequate for effective community nurse case management and high workloads affected quality of care. However, a number of compensatory mechanisms, such as targeting/prioritizing and documenting unmet need, were in evidence and, in higher scoring cases, job satisfaction was a notable feature, suggesting there was an ability for individuals to overcome negative contextual influences to a certain extent.

- A relatively large number of cases tended to show a profile of long-term and anticipated continuation of the community nurse case management role, however "best" cases appeared to be differentiated in that the impetus for this was derived from local, rather than national, policy issues.

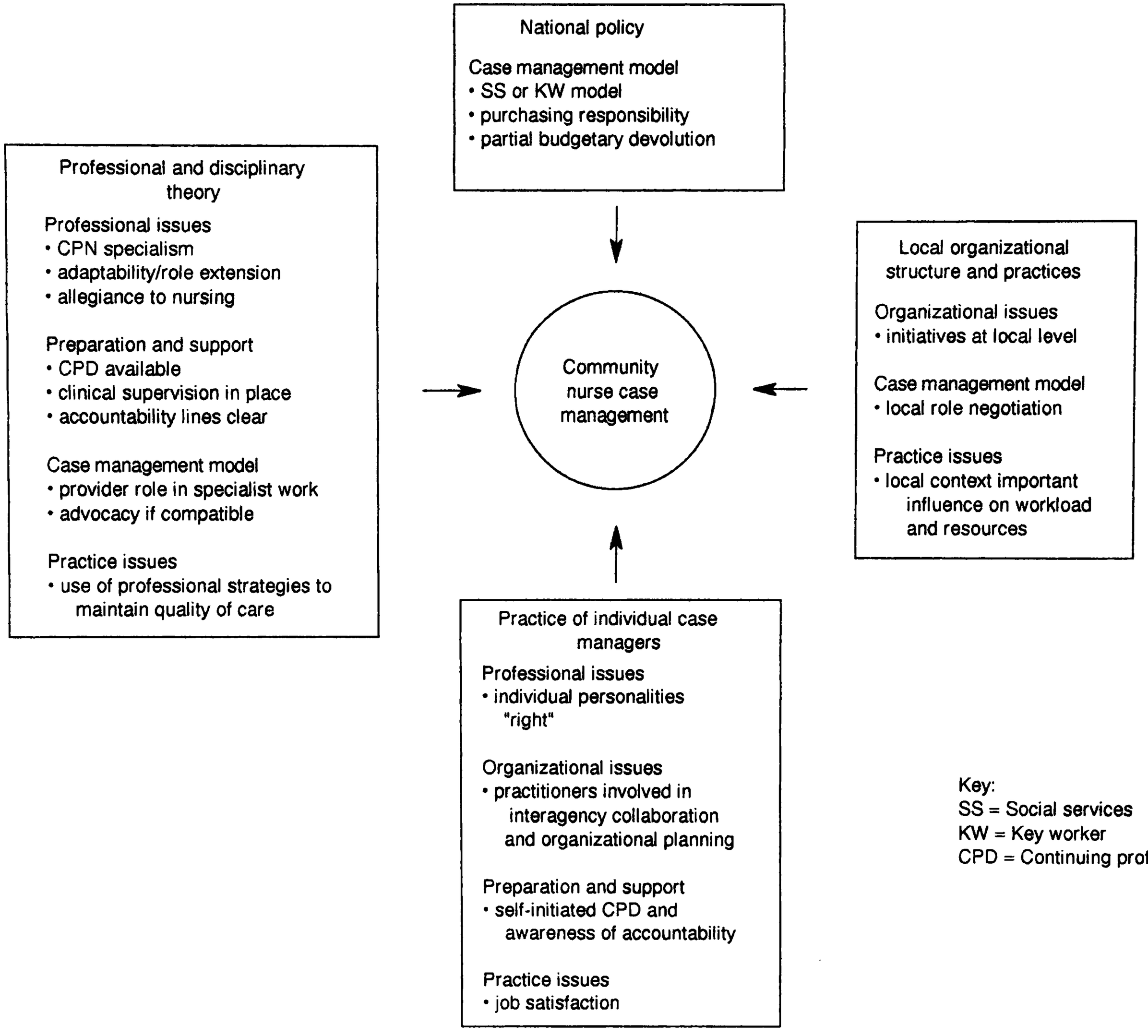
Cross-case analysis allows for the construction of an "ideal-type" of community nurse case management (fig. 3.5) through replication logic, which depends upon the fulfilment of all of the conditions described; partial fulfilment was found to produce an incomplete picture. This model was based on, and tested out successfully, the four levels of evidence depicted in the research method (fig. 2.4), itself based on the framework of the literature review (fig. 1.1), thus linking all stages of the research conceptually.

3.7 Overall discussion, conclusions and implications

3.7.1 Discussion of research topic and findings

Case management has proved to be both interesting and challenging to explore as a research topic. The interest derived from its "novelty" status at the time of study, achieving, as it did, a high profile in health and social care following the NHS and Community Care Act, 1990. The challenge arose from its relative lack of clarity as a concept in operational terms, especially within community nursing, and also because it was set very much within a fast-changing social and health policy context. Yet it is felt to have been an interest worth pursuing and a challenge worth taking up, not only to address, within a nursing framework, an issue not primarily conceived of in nursing terms, but

Fig 3.5 Model of "ideal" community nurse case management as identified by cross-case analysis



Key:
SS = Social services
KW = Key worker
CPD = Continuing professional development

also to explore, through a particular research method, whether concepts set within a fast-changing contextual agenda are actually "researchable". In both respects there was scope for advancing practice and research-related knowledge.

The summary findings presented at 3.3.8 and 3.6.8 suggest that, to a certain extent at least, the main objectives set out at 2.2 have been addressed, indicating the matter to be, indeed, researchable. The intention here is to take a step back and consider, in the light of these findings, the broader research aim, which focused on both "current" and "potential" scenarios and on explaining the link between the concept of case management and the discipline of community nursing.

At its most simplistic level, the descriptive data demonstrate that case management has a capacity to endure, at least in community mental health and learning disability nursing, despite its apparent fall from the social and health care policy agenda. It has also been possible to define, through pattern-matching within and across cases, the conditions likely to produce optimum community nursing case management practice. The issues, if not the actual title "case manager", have been embraced into nursing roles as they are played out within changing contexts, and initiatives cited in the follow-up data (section 3.5) of the restoration of community nurse case management within integrated structures, are examples of responses to a recent political climate more conducive to interagency cooperation. However, a deeper reading of the data suggests that it is not only the politico-social context which is subject to change, but that (community) nursing itself possesses an innate ability to transform and recreate itself at a local and individual level, in order to function effectively within prevailing policies, yet without compromising its own essential core values. A synthesizing analysis of how the "best" cases and individuals identified in the research related to the other three levels of contextual variables outlined in fig. 3.5 (national policy, professional theory and local organization) will, it is hoped, shed some light on the dynamics of this mechanism and thus allow for a degree of generalization that may inform future community nursing case management.

Firstly, it must be said that case management as a concept in the UK has been seen very much as a social policy issue. Despite its origins in North America (Beardshaw and Towell, 1990) and the claims of some of the research cases to have initiated the practice independently, the main impetus behind its popularity in the UK was undoubtedly the community care legislation of the late 1980s and early 1990s (DoH, 1989a and sequelae), which, it has been noted, supported the potential for community nurses as case managers. It will be observed that this is not an unusual feature of current nursing practice; indeed, the study of the nursing literature (section 1.4) has already suggested that at least some nursing developments of the 1990s were also politically motivated (Wright, 1994), while some of the more recent nursing role developments (for example nurse prescribing, nurse consultants, involvement in PCGs, Personal Medical Services (PMS) Pilots, NHS Direct and Walk-In Centres) have occurred in tandem with, if not been dependent upon, new legislation.

However, it would be obviously over-simplistic to conclude from this alone that case management as a policy ideal is an appropriate model for community nurses, even where empirical evidence has shown it to be a feature of practice. Policy statements, as previously noted, are necessarily vague, giving rise to interpretations which may not coincide with policy-makers' actual intentions (Trnobranski, 1995) and it is the nature of policy outworking in practice which is the focus of the research enquiry. This may be traced by comparing the literature (section 3.5, table 3.12) with the cross-case analysis and noting its interpretation in the "best" cases.

Policy statements were largely concerned with the model of case management envisaged. It has already been suggested above that, because community care was seen as having a social services' orientation, case management itself was interpreted as an obvious role for social workers (DoH, 1989a), with a micro-level focus typical of the social services organizational culture (Challis 1994a). Further, policy documents appeared to recommend the separation of purchasing/ assessment and provision (DoH/SSI, 1991a, b) and budgetary devolution (DoH 1989a, 1990, DoH/SSI 1991a, 1991b,

SSI/RHA 1993b, NHSE/SSI 1994). However, it has also been noted that such statements reiterated a desire not to be prescriptive and were couched in ambivalent wording (DoH, 1989) which facilitated this. Thus the "best practice" found in the research tended to display these characteristics only to a degree; models of case management contained elements of the keyworker, as well as the social services dimension, they possessed some, but generally not complete, purchasing power, and this was usually based on partial budgetary devolution (fig 3.5). The research supports the argument that such "implementation deficit" (Trnobranski 1995) is due to the need for policy pronouncements to be congruent with the three other types of contextual variables outlined in the model.

In terms of professional theory, the second of these variables, the main debating ground when considering community nurse case management concerned the policy preference for case management to be a purchaser function, with separate provision and advocacy elements. "Best" case respondents tended to support both sides of the debate illustrated in the professional literature that, on the one hand, the historical provider role of nursing cannot be easily relinquished with the acquisition of new roles and responsibilities (Hunter 1988, Bergen et al, 1996) but that, on the other hand, the introduction of a more dilute skill mix (NHSME, 1992) and increasing opportunities for commissioning (Barton 1995) mean the very basis of nursing practice must be changed. In practice, the best community nurse case managers coped with this in one of two ways, either by adopting a concept of case management commensurate with nursing values ("mediators") or by moving to the boundaries of the nursing role and identifying more with a given specialism or with case management than their profession of origin ("adaptors" - fig. 3.1).

A further issue to impact strongly on both case management and professional nursing theory was that of quality assurance, in particular the balancing of need with available resources. Policy commitments both to a needs-led service and to prioritization of those with greatest needs (DoH, 1989a) led to predictions of the inevitability of "implementation deficit" in the form of rationing through eligibility criteria (Smith 1993, Johnson 1993). The importance of quality as an

ideal also within the nursing literature (NHSE, 1993) meant professionalism might thus be potentially compromised in the assumption of the case management role. However, case managers in the research countered this through a number of coping mechanisms, such as targeting, limiting their vision to a particular specialism, or looking outside traditional provider agencies, which, in the "best" cases, appeared to lessen the needs-response gulf. Less amenable to resolution was the tension between competing individual and population perspectives of case management, both as policy and within the nursing ideal. In neither case was guidance in evidence (Lewis and Glennerster 1996, North 1997, RCN 1995, Luker 1997), and the setting of nursing within the macro-orientated purchasing of health care framework sat uneasily alongside the micro-purchasing social services policy orientation. Community nurse case management within the research cases coped with this largely through the strategy of documenting any unmet individual needs, in the expectation that the information would feed into future resource planning. Moreover, the more recent legislation (DoH 1997, DoH 2000) itself appeared to be moving towards a position which would facilitate the link between the two (health and social services) viewpoints as they worked together.

A third major issue of importance to both nursing and policy makers was that of professional education and support. However, while nursing as a profession has, arguably, always concerned itself with the adequacy of preparation of its practitioners (Kemp and Robertson 1994, Millard 1995, Hatfield and Mohamad 1996), training for case management, though supported in policy, was not mandatory (DoH, 1993a, DoH/SSI 1991a and b) and this led to concern, even in the official literature, for its adequacy (SSI/RHA 1993a). The same appeared to be true for clinical supervision at a time when it was assuming a greater profile in nursing (NHSE, 1993). These issues were of added importance in view of the increased accountability accruing to community and other nurses assuming new, more autonomous roles (such as case management), despite the apparent dearth of policy literature appearing on the issue. The research found that, while availability of professional education was variable, professional support was largely in place across all the cases, and

partly compensated for the situation in cases where there was a lack of professional education freely available.

The third contextual dimension likely to be of importance in discriminating successful community nurse case management was the local organizational structure (fig. 3.5). Once again, it may be observed that local initiatives have always been influential in defining practice more widely - witness, for example the "flagship" Community Nursing Development Units (NDUs) such as Strelley (Twinn, 1996), or the more recent publicity surrounding the decision of Rochdale NHS Trust to apply for "magnet" status (Aiken et al, 2000). It cannot, of course, be denied that both of these enterprises were themselves strongly influenced and facilitated by the wider infrastructure (government funding in the first instance, the North American accreditation system in the second), but, without such local efforts it is questionable whether such innovatory ideas would ever become part of accepted practice. Just so, in the example of case management it is interesting to note that particular geographical localities (such as Kent, Gateshead and Darlington) recur in the literature and have become associated with particular models of case management.

Official policy, in terms of the White Paper on community care (DoH, 1989a), has been noted for the variation it allowed, at the local level, for implementation in such areas as defining health and social care responsibilities, the degree of separation between purchasing/ assessment and provision, budgetary devolution, prioritizing client groups, case manager preparation and supervision and, fundamentally, the profession(s) from which case managers should be drawn. Despite charges that this approach led to organizationally unclear roles (Challis, 1994b) and calls both in the nursing and case management literature for logically coherent structures to be in place (Bond 1993, Rodgers and Fry 1994, Morrish 1995, Challis 1994a), this very lack of prescriptiveness allowed for the diversity at local level which characterized the research case study sites. In the "best" cases, community nurses were involved in implementing case management at the local level and there was evidence of good local interagency collaboration over roles and responsibilities, which led to recognition

of their role within the locality. Moreover, a margin for variation in policy interpretation allowed community nurses to work within a nursing framework, negotiating their roles regarding the issues discussed above and consistent with their own vision for practice.

This personal vision was very much part of the fourth and final contextual dimension informing effective community nurse case management - indeed, the very research method itself was based on individuals' perceptions of their practice as obtained through personal interviews. As with the previous dimensions, precedents can be found for the impact of this variable on nursing practice from the universally acknowledged influence of Florence Nightingale, to more recent nurse leaders such as Lance Gardner and Catherine Baraniak, heading up the first nurse-led PMS Pilots (Baraniak 2000, Bayliss 2000). These are, of course, the trailblazers in nursing, but it is likely that such individual influence is not uncommon across nursing, as suggested by the classic research on the influence of ward sisters in the early 1980s (Fretwell 1980, Orton 1981, Pembrey 1980) and more recent publicity surrounding candidates for the Millennium Nurse Award (Nursing Standard, 1999).

Some commentators have argued that the framing of social policy allows for individual, as well as more corporate local, responses and interpretations (Caldock 1994, Lightfoot 1995, Roberts and Priest 1997). In the case management literature the importance of the individual has been highlighted especially with respect to implementation, interagency working and professional education, and this is consistent with nursing and political theory, and also the evidence found in this research. For example, Lipsky's (1980) concept of "street level bureaucracy", outlined in previous sections, is echoed in Nolan and Chung's (1996) assertion that nursing theory is often defined by practitioners, while Beardshaw and Towell (1991) made a case for the involvement of individual staff in the implementation of case management. "Best" cases in the research similarly demonstrated feelings of involvement by practitioners in a "bottom-up" approach to implementation.

There was a similar consistency through all the "levels" of literature in the support for interagency collaboration but, at the same time, an acknowledgement that this may be problematical to put into practice at the individual level in policy implementation (NHSE/SSI, 1994), nursing (Higgins 1995, Sibley 1997) and case management projects (Dant, 1989). "Best" cases in the research appeared to have overcome these problems and demonstrated good interagency working, especially at "street" or practitioner level and within the mental health discipline. Of interest was the repeated comment that individual personalities were important in this.

Personalities probably played a similar part in the uptake of educational preparation for the case management role, since "best" case practitioners tended to have been studying at bachelors' or masters' levels and at their own volition. This need for professional development, together with a voiced concern for the adequacy of employer-led courses, is a theme across policy (DoH 1993a, SSI/RHA 1993a), nursing literature (Kemp and Richardson 1994, Millard 1995, Hatfield and Mohamad 1996) and case management literature (Challis and Davies 1986, Meethan and Thompson 1993, Wilson 1993).

The conclusions to be drawn from this analysis *vis a vis* the research aim may be expressed through a review (fig. 3.6) of the conceptual model put forward in the discussion on data analysis in section 2.6.

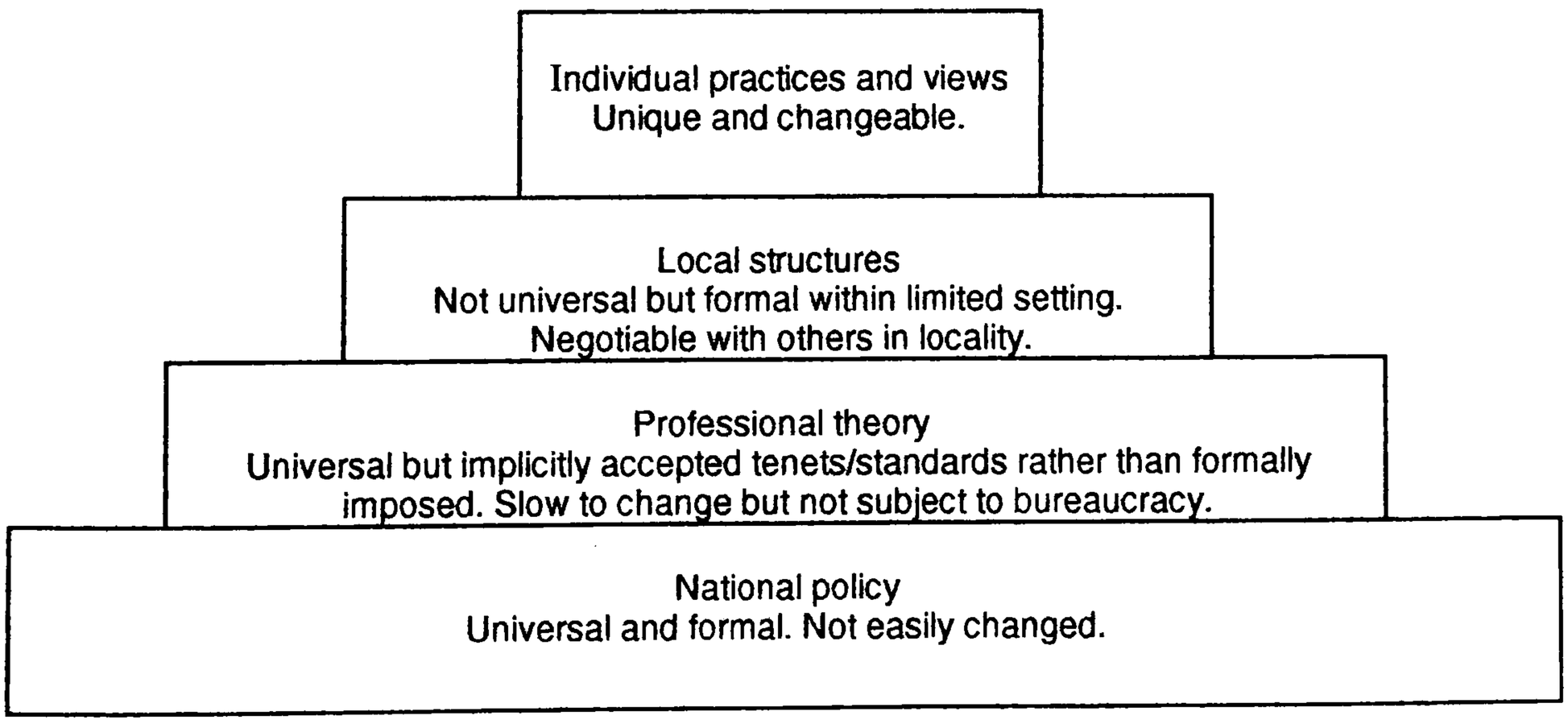


Fig 3.6 Model of four levels of influence governing community nurse case mangement.

This set out the four levels of influence governing community nurse case management practice, together with their associated perceived degrees of universality and formality. It has been shown that the best examples of community nurse case management demonstrated fulfilment of a number of conditions related to each of the propositions which guided the analysis and which covered these four levels. It was found that each of these on its own provided a necessary, but not sufficient, precondition of effective community nurse case management over time. It may also be seen that these levels themselves are interrelated. Herein, it is suggested, lies the particular contribution of this piece of research, that is, not so much in the individual pieces of information regarding the operationalization of community nurse case management, much of which is supported in the literature elsewhere, but in the way this information has been linked into an integrated framework comprising four major determinants.

Firstly, legislative policy was foundational to the concept of case management in the UK. It was largely perceived as remote and unchangeable, since its facilitatory nature, arising from a lack of prescriptiveness in its operational guidelines, was not necessarily grasped by community nurses (except, perhaps, in the case of the mental health specialism, where separate legislation, in particular the CPA, governed related concepts). However, the anticipation, at follow-up, that community nurse case management may be reintroduced, or enhanced, in the future, was largely due to an awareness, in some cases, of the potential of the post-1997 reforms - notably in the area of improved interagency collaboration - to work to nursing's benefit.

Secondly, it was also apparent that social and health policy promoting case management needed to be congruent with professional ideals and structures before it could be embraced within the nursing culture. Where this was not perceived to be apparent, some community nurses moved to one of two polar positions, either aligning themselves with a social services-orientated case management, which left little room for nursing, or with professionally orientated practice, which bore little

resemblance to case management. These approaches tended to reinforce the view of national policy as immutable, and to emphasize as equally immutable the inability of nursing to exert its influence in the policy arena, where it has been noted that the market culture, efficiency and productivity took precedence over professional codes (Hatfield and Mohamad 1996, Bovell et al 1997). But, while it may be true, as Davies (2000) has said, that "nursing never makes policy in circumstances of its own choosing" (p.24), it has also been suggested (Trnobranski, 1995) that there is room to interpret and implement policy "imaginatively" and, at the same time, to capitalize on the ability of nursing, noted in the literature review, to adapt to changing contexts. Indeed, the "middle range" scenario depicted at section 1.4.6 can be seen to have been played out successfully by the "mediator" community nurse case managers in the research (table 3.20). Kesby (2000) has argued that the reason this does not occur more generally is that the profession has failed to take a lead in creating a cohesive national nursing policy which may be used as a framework to devise local strategies. This argument would seem to possess at least a degree of credibility, since these strategies may help to formalize nursing theory, freeing it from its implicit immutability, which may hinder progress.

Thirdly, both national policy and professional ideals needed to be perceived as congruent with the local organizational strategies in order to facilitate effective case management. With the conducive potential of both policy and professional levels realized, local practices and policy changes should be more in evidence, such that the "best" research case scenarios of, for example, good local interagency working (section 3.6.3) may occur because, rather than in spite of, central policy and traditional theory. There is reason to suppose, from the follow-up data, that nurses may, indeed, be grasping this potential, as evidenced in the spontaneous comments regarding the involvement of community nurses in PCGs and the opportunities which this may provide. Kesby (2000) has suggested that this restructuring at locality level may strengthen the position of district nursing, in particular, in determining its own destiny.

Finally, these three levels of influence need to be acceptable to the individual practitioner-case manager in order to optimize practice. The importance of the "personal" in the construction of nursing theory has already been noted in the literature (section 1.4.2) and the role of individuals and personalities has emerged from the research data (sections 3.6.3, 3.6.4, 3.6.6). "Best" case managers were observed to have put personal effort into forging interagency relations at the practitioner level, harnessed education to improve their practice and grasped opportunities presented by central policy and professional experience to work in a way which led to job satisfaction. "Street level bureacracy" (Lipsky, 1980) appeared to be an integral part of this equation.

In conclusion, therefore, the relevance and value of case management to community nursing may be said, in this analysis, to have depended on the fulfilment of certain identifiable criteria concerned with professional issues, organizational issues, preparation and support, case management model, practice issues and community nursing specialism (section 3.6). These, in turn, appeared to be governed by the interrelated impact of four levels of contextual variables, which may be constructed into a conceptual model. However, perceptions tended to be based on assumptions which over-emphasized the unalterable nature of these variables, particularly at the more remote (policy) end of the spectrum, often to the detriment of practice. It is suggested that plans to introduce, or develop, community nurse case management or, indeed, new practice roles more generally, should, therefore, take into account these underlying influences, and a set of recommendations for practice may be specified, based on the research findings

3.7.2 Implications for nursing practice

This research has suggested (section 3.7.1) that, in the best examples of community nurse case management, practitioners were able to embrace change at a local and individual level, without compromising core nursing values, and that this is a characteristic of the ability of nursing, more generally, to transform itself in order to function effectively within prevailing social and health policies.

Clearly, this ability needs to be promoted if nurses are to assume, not only the role of case manager, but, by implication, other roles similarly linked to policy issues. The means to achieving this are worthy of analysis using the framework of contextual variables which forms the core of this research, that is, focusing on the policy, theory, local organizational and individual dimensions.

The ability of nursing to function at the national policy level has been questioned by commentators such as Kitson (1997a) and Kesby (2000) who have argued that the absence of a nationally coordinated structure to ensure nursing is included in the health care policy agenda is restricting the profession generally. The lack of any apparent nursing input into the community care White Paper (DoH, 1989a) which heralded case management as a policy ideal may, at least partly, account for the distancing from policy felt by many of the respondents interviewed in this research. Moreover, there is some evidence that the situation persists in relation to more recent issues where the nursing input is seen to be marginalized, for example funding for long term care (Ford, 2001) and for various treatments, such as multiple sclerosis (Nursing Standard, 2001).

The question of how to improve the nursing representation at this level is, however, complex; Kitson (1997a) herself has acknowledged that what is required is a fundamental shift in prevailing attitudes and that the necessary support of the wider community to achieve this may not be forthcoming. This, in turn, may necessitate a refocusing of influence on the locality and its structure, which may provide more realistic operating parameters (see below). Others, on the other hand, have argued that, just as policy changes are fundamentally linked to nursing practices (Kesby, 2000), so nursing should be involved in defining its role where its areas of expertise are at stake. One such area is that of quality; Traynor (1999) has argued, for example, that the NHS reforms served to change nursing discourses (frameworks for debating the social world), by promoting an emphasis on "effectiveness" and "outcomes", an area in which Klein (1998) has suggested that the nursing voice should be heard in defining how "performance" is measured through negotiating and bargaining at the frontiers of the NHS. But, fundamental, perhaps,

to the ability to articulate nursing at policy level, is sound research (McMahon et al, 2000), which underpins a theoretical framework from which to achieve the necessary power base envisaged in the Foucauldian interrelationship between knowledge and power (Du Plat-Jones 1999, Traynor 1999). This underlines the importance of professional theory to a discipline and is the second of the contextual variables to be addressed.

The extreme variability of practice models for community nurse case management within this research appears to be consistent with other recent findings related to community nursing theory which, in turn, call for change at this level in order to promote effective practice and new roles. This variability appears to apply across community nursing specialisms; studies of district nursing work (Smith et al 1993, Goodman 2001, Worth 2001) have commented on its complex, discretionary, individualistic, unstable, pressurized nature, which makes it poorly understood and lacking in authority, while reviews of the work of CPNs (Godin 1996, Ryan et al 1998) have made similar points about unstandardized, undefined and competing elements within a discipline lacking in overall practice theory, leading to its marginalization within the wider health care community.

There was, further, a dichotomy of practice "types" found in this research ("mediators" vs. "adaptors"), which is commensurate with much of the professional literature reviewed (table 3.13), as well as more recent work (Ryan et al 1998, Worth 2001), which exhibit opposing arguments around issues such as the purchaser vs. provider debate, maintaining ideals vs. workload constraints, health vs. social care and the individual vs. population focus of practice. Traynor (1999), in describing a similar dualism noted in textual analysis of interviews with community nurses, has argued that professional groups actually depend on such dualistic language to promote their own, as opposed to the "other", position (for example in the way practitioners emphasize their allegiance to "care" in the face of tightening financial control and bureaucracy), which is unhelpful. Although, claimed Traynor, it is impossible to do away with these powerful systems of thought altogether, it is possible to destabilize

them, though just how this destabilization should be brought about is not made clear. However, Worth's (2001) study of district nursing work found that those working in a case management capacity exhibited a more readily adaptable value sysem, which lessened the dichotomy between nursing and social care roles.

Of course, no discussion of community nursing theory can take place without some acknowledgement of the context-dependent nature of its practice (Godin 1996, Goodman 2000, 2001, Ryan et al 1998, Worth 2001), that context being characterized by frequently changing policies, structures and interprofessional relationships, as noted in this research. In such a situation there is a danger that if community nurses are not able to articulate a contribution capable of adapting to the changing context, then, as Ryan et al (1998) found, in relation to CPNs, their role may be defined (maybe inappropriately) for them. Indeed, one of the features of a number of the case studies of community nurse case management was a relative isolationism and helplessness in the face of unsympathetic management and a government policy perceived to be dictating professional practice (for example cases 2 and 3). Perhaps here was a missed opportunity to claim an emergent, and initially somewhat undefined, role by a community nursing workforce who were potentially its most appropriate executors. It may be hoped that the opportunities seen by some as being presented by modernization, including regaining case management control (Wilkin et al 2001, Kesby 2000), are not similarly lost and whether, for example, the prospective role of health facilitator, proposed in the recent White Paper focusing on the learning disability specialism (DoH 2001) is assumed more readily by community learning disability nurses, as has been urged (Beacock, 2001).

The themes of professional power and disempowerment are also replayed within the literature related to the local level, the third contextual variable under scrutiny, where Kitson (1997a), as noted above, saw a role for nurses; indeed, a postmodernist reading of the situation (for example Traynor, 1999) would emphasize the "local" above the "universal". Here, the power element appears in the literature as portraying a picture of community practitioner

exploitation and subordination at the hands of more powerful managers (Smith et al 1993, Traynor 1999) or other groups of professionals (Godin 1996, Goodman 2001, Ryan et al 1998). Writers on the work of mental health nursing, in particular, have depicted a picture of CPNs as engaged in an ongoing struggle within multidisciplinary teams to escape such subordination by finding autonomy in areas of practice where they can maintain some kind of monopoly (Godin 1996, Ryan et al 1998). With district nurses, distancing and disempowerment have been seen in relation to managers (Smith et al, 1993), insofar as they are sometimes seen as self-protecting, and within the primary health care team (Goodman, 2000), where joint working remains poor (Kesby, 2000).

Certainly these findings resonate with this research, where role recognition by colleagues, interagency collaboration and involvement in local restructuring was in evidence with the "best" examples of case management, but was a significant concern for others. Various means of addressing local inadequacies have been seen to include taking a more active part in organizational arrangements and claiming autonomy of role (Godin, 1996), integrated working with social workers (Worth, 2001), being involved in the "partnership" arrangements for learning disability (Beacock, 2001) and capitalizing on the opportunities afforded by primary care groups and trusts for collaborative discussion and action (Goodman 2000, Kesby 2000). In particular the active participation of professional subgroups that advise primary care trust boards has been seen as a major way for community nurses to influence the planning and commissioning of health care for local populations (Kesby, 2000), thus, presumably, linking the individual to the population focus which proved so problematical with case management.

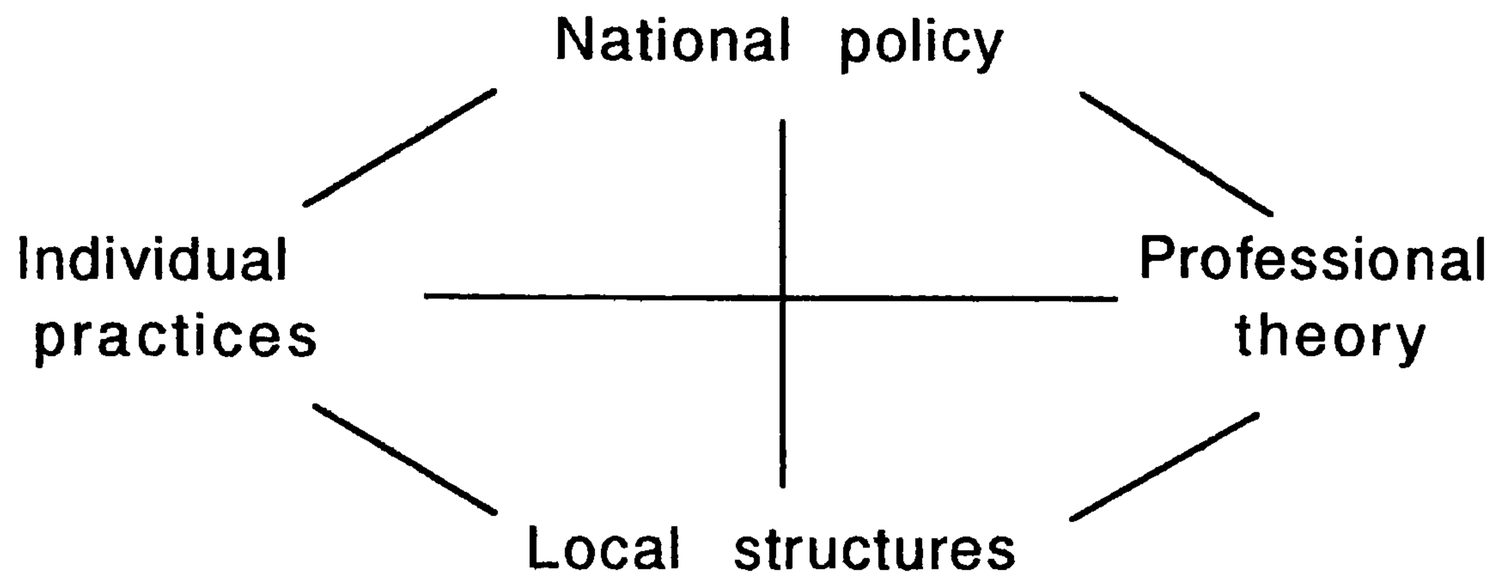
So, although there were some successful examples of community nurse case management in the research, in other areas it may be questioned whether the concept was somewhat ahead of its time, that is, before adequate local structures and cultures were established. The experience of case 7, which eventually terminated despite the almost charismatic enthusiasm of the postholder, in a poorly supportive environment, stands as a possible testimony to this. Even

so, the current local context may be questioned as being more appropriate; the recent decision by the Government in England to fund nursing, but not "personal" care in care homes, as part of its promises in the NHS Plan (DoH, 2000), appears to have reawakened the nursing profession to the need to defend and assert a professional definition of "nursing" (to include care delegated by a qualified nurse), so that what is seen as a falsely separated "personal" element may be reclaimed by the community nurses who will be responsible for the assessment for such care (Kesby 2000, Ford 2001). Until this latest issue for interagency collaboration is resolved, it is doubtful whether the joint working, also envisaged in the Plan, and a precondition for case manager-type roles, will be completely effective.

Finally, the individual level, noted as important from many comments and interview experiences in this research, must not be overlooked. Although, as Goodman (2000) has said, it is dangerous to suggest individuals should change without, at the same time, addressing the context of pactice, Kesby (2000) has, like this research, noted the informal, personal level networking which takes place and the practice development in evidence at individual practitioner, if not at the strategic, level. Further, it appears that the nurse "on the ground" will be responsible for deciding the difference between nursing and personal care needs in the emerging long term care scenario described above (Dinsdale, 2000), which will underpin the new relationship with social services and other care personnel. Roles will necessarily change and the implications noted in the more recent literature still echo the characteristics of the more effective community nurse case management cases: further resources for training to empower practitioners and raise interprofessional understanding (Traynor 1999, Worth 2001), the acquisition of new skills associated with case management practices (Godin, 1996) and a commitment to new approaches to care and to extending practice self-developmentally (Ryan et al, 1998). In other words, a personal willingness to adapt and personal energy put into ongoing professional development remain vital components for the current community nurse.

In summary, therefore, a number of general implications may be put forward emerging from both the research and more recent literature, which should guide any introduction of community nurse case manager type practices in particular and, in terms of the focus on congruence between the four types of underlying influencing variables (fig. 3.7), may also apply more generally to current and emerging community nursing roles:

Fig 3.7 Linking the variables influencing community nurse case management



- Policy - there is a need for corporate and individual familiarity on the part of nurses, with health and social care legislation (such as that promoting case management) and an ability to interpret this within a nursing framework. There is a further need for a mechanism for the nursing voice to be heard at policy level in areas of professional expertise, such as quality assurance.

- Theory - a better integrated theory of community nursing practice would, as well as facilitating its representation at policy level, help practitioners to cope with its diverse and undefined nature and assert their place (in case management or other roles) within the changing local context.

- Local organization - Current changes in local structures, such as the formation of primary care trusts, present an opportunity for community nurses to take an active part in commissioning, planning and implementing health care for individuals and local communities (the management of care/care management) and work towards equitable provision of nursing in collaboration with other professionals.

- The individual - a personal commitment to professional development and a willingness to adapt practices is becoming necessary to take on appropriate roles (such as case management) as well as a personal vision to motivate this.

3.7.3 Discussion of research methods

Just as case management itself has proved to be both interesting and challenging, so have the research methods employed to explore the concept. The most notable area of interest from the research perspective probably lay in the development and application of the case study method in the third phase of the study, while the major challenge arose from the need to integrate the different phases of a complex, multimethod approach. Further challenges lay both in the acknowledged difficulty of researching the topic of case management and in the fast-moving context within which it was set. For example, the literature review attested to the problems both of establishing universally accepted definitions of case management (section 1.1.3) and of establishing appropriate outcomes (section 1.3.3), and choosing appropriate methods from the variety in evidence in the research reviewed (section 3.3.4). Further, the changing context involved time devoted to coping with, for example, variable and changing job descriptions, with the implications that had on consistency and methodological rigour. These general observations apart, there were issues arising from each phase of the study and these will be considered in turn.

The telephone and questionnaire surveys were, to a certain extent, subject to the potential strengths and weaknesses of all survey-type research, too familiar to rehearse here in detail. However, they were felt to serve well their purpose of identifying suitable samples for the subsequent phase of research. This particularly applied to the telephone phase, since sample identification was largely its *raison d'être*, though other evaluative comments on this phase were documented in the findings section (3.2.2), as a sub-aim. One potential weakness not realized with the questionnaire survey was the response rate, which, at an encouraging 68%, and despite some

poorly completed forms, was felt to provide sufficient information from which to select cases which seemed to reflect case management practice. With hindsight, one case (9) stands out as not living up to expectations in this respect, which, to some extent, discredits the method. However, this was also found to be a useful "marker" in the case study phase, against which to contrast varying degrees of good practice.

The longitudinal follow-up, too, was subject to the advantages and drawbacks of that particular method, as outlined in section 2.7.3. However, the major potential weakness of sample attrition here, made more likely by the fact that the study was not originally set up as a longitudinal design, was not fully realized. As noted earlier, the existence of a precedent for this change to the original plan was a spur to its introduction, and the response rate (90% for questionnaire respondents, $^{9}/_{13}$ managers and $^{16}/_{16}$ community nurses in the case studies) was felt to be vindication that it was a useful adjunct to the overall design. In particular, the ability to identify change at the micro, as well as the macro, level, through the panel design (2.7.3) was helpful, in view of the importance of the individual and the local levels to overall patterns of practice. Further, the significant shifts in the policy context which took place over the duration of the research were able to be accommodated through this means.

The case study phase, as well as being of greatest interest, also presented the greatest methodological challenge to the research, since there exist many documented ways of interpreting the method (section 2.6.3), necessitating a clarification of basic terms, such as "unit of analysis" (sections 2.4.3 and 2.6.4). Nevertheless, the definition provided by Yin (1994) was found helpful and the methods section (2.6.4) provides a detailed account of the general issues surrounding case study research and how Yin's broad precepts were interpreted and operationalized. The analysis, in particular, proved time-consuming and, because little detailed guidance is provided in the literature here, there are a number of areas where researcher discretion was necessary, leading to potential weaknesses in the design.

Although the analytical approach, based on pattern-matching, appeared to work successfully, within Yin's (1994) typology, it also presented a challenge in that it constituted, in essence, a positivist approach, using a set theoretical framework, in a deductive mode, but set within a context of rapidly changing health policies and organizational structures. The tension inherent within this approach reflected that already noted in the literature reviewed (section 1.3.1) between the ideals of policy pronouncements emanating from the government of the time ("top-down" evidence) and the practice reality represented in the way this was interpreted by practitioners and those responsible for policy implementation ("bottom-up" evidence).

This tension poses questions about the very notion of "truth" in research which may be viewed as reflecting either one end or the other of a series of dichotomous dimensions, as illustrated in fig. 3.8.

Fig. 3.8 Dimensions of "truth"

The framework	The data
General/universal	Local
Macro focus	Micro focus
Positivist	Constructivist/relativist
Fixed	Variable/changeable

These represent, on the one hand, the theory which constituted the conceptual framework and, on the other, the data collected as part of the research, to be "matched" with the theory. The first of these dimensions has been highlighted by, among others, Traynor (1999) in research where he has commented on the contemporary tendency to move from a universal justification for the foundation of knowledge, to a locally-based, contingent knowledge which emphasizes differences, rather than commonalities. The second set of characteristics, linked to the first, focus on the changing emphases between the macro policy arena and the micro policy level representing contextualized, local knowledge, produced by

interpretive and ethnographic research methods (Scott and West, 2001). The third contrast is between seeing the reality of experience as fixed and discoverable (positivist) and seeing experience as flexible and shaped through interaction with the world (constructivist) (Vallis and Tierney, 2000)); the recent move towards the latter in support of Traynor's (1999) localized knowledge has itself come under the criticism of those who cast doubt on the validity of postmodern approaches, in view of their individual and relativistic nature (Scott and West, 2001). The fourth, and final, dimension highlights the relatively "fixed" nature of the positivist approach versus the changeable nature of context-dependent data. Indeed, Becker (2000), in discussing the inductive construction of a narrative, has suggested the need for a continuous redefinition of what the theory is explaining and what the dependent variable actually is, while Slevin and Sines (2000) have made the more universal point regarding research that, in view of its timespan, by the time most studies are completed, changes may have occurred that will render the findings out of date.

The competing claims to reality of all these dimensions were apparent in this research, with the researcher standing between the two dichotomous sets. The challenge lay in establishing a balance which would both exploit the strengths and minimize the weaknesses of each approach, an ability which Bryar (2000) has ascribed to the best examples of case study research, where the method is applied rigorously in order to achieve the isolation of selected factors within natural settings. Further features of the research which served to minimize the tension within the analytic method pertained to both the theoretical framework and the data. It should be noted that the former was constructed from preliminary observations, together with literature produced over time, that is, based on ideas, features and concepts which were reasonably broad, but stable enough to allow categorization at time intervals (for example the proposition that district nurses make suitable case managers). Regarding the latter, the data were categorized in such a way that would similarly allow for change, indicating movement towards or from the propositional statements (for example by identifying that district

nurses were becoming more or less involved in case management at follow-up).

There are, further, a number of more specific areas where the robustness of the case study method may be open to debate. Firstly,it remains questionable whether non-equivalent dependent variables as patterns, or rival explanations as patterns is the more robust strategy. The main weakness of the latter choice, which was eventually adopted, is the lack of a pre-test, which would have been difficult to coordinate with a post-test, since policy was being introduced over the case sites at different times. However, the approach may be feasible where the introduction of local change is under scrutiny, based on a single case design.

Secondly, although not explicitly documented elsewhere, using reviewed literature as contextual data was considered a viable option within a research method which laid stress on the importance of context (Yin, 1994). The three levels of contextual data (fig. 2.4) were, together with individual case management practices, designated units of enquiry and thus the subjects of the research. Then, just as data pertaining to the subject matter (units of enquiry) of the first (telephone survey) phase of the research subsequently became the source (sampling units) for stage two (questionnaire survey), so the contextual data relating to the case studies moved, over the four-stage analysis process, to become sampling units, through the construction of the propositions with which single-case data were "matched". This process could lay the research open to a potential charge of over-complexity and (in view of the iterative nature of single-case matching) to repetitiveness. However, attention to detail is felt to be at the very heart of case study research and meticulous documentation is seen as a fundamental guarantor of reliability (Yin, 1994, p.33). The same transparency through comprehensive pattern-matching, replicated over the total number of cases, was felt similarly to maximise internal and external validity respectively.

A third potential weakness lay in the difficulty of establishing construct validity. Although Yin's (1994) recommended tactic of using multiple sources of evidence was (at least nominally) adopted,

there was a noted imbalance in the resulting data from the triangulated sources. While practitioner and manager interviews comprised the major evidence base, documentation proved minimal and, on the whole, unhelpful, while securing user interviews proved difficult, as predicted in the literature, due to the highly vulnerable nature of case management users (section 2.6.6). This weakness is difficult to resolve, since the more articulate sevice users are less likely to be subject to case management.

A fourth difficulty for case study analysis follows again from the lack of detailed guidance in existing texts, specifically in relation to the precision of pattern-matching, and the need for what Yin (1994) described as "interpretive discretion" (p.110, see section 3.4). The very diverse threads of theory emerging from the literature against which to "match" empirical data were synthesized through three refinement processes (identification of variables, table 3.11, matching contextual variables, table 3.12, constructing propositions, table 3.13). Again, such detailed documentation of research processes was felt necessary to enhance reliability, though, even then, the wording of propositions was occasionally complex, giving rise to subsequent problems with the validity of the matching process (for example regarding budgetary devolution, discussed in section 3.6.5). However, to a certain extent, this problem of meaning was offset through attention given to the more detailed comments of respondents elaborating on a particular issue.

The problem of pattern-matching was further addressed through visual representations, in the forms of tables (3.17 - 3.25) and figures (3.1 - 3.4) highlighting where particular cases fell in relation to the issues in question. The same charges of both reductionism and repetition may also be levelled against these strategies, however, they were felt to facilitate the process of making sense of complex and detailed data, and consistent with Yin's (1994) view that gross matches or mismatches through an "eyeballing" technique are sufficient for drawing a conclusion, pending the development of more precise methods. Once again, the scrutiny of more qualitative respondent comments buttressed the claims to both validity and reliability here, where data analysis again called for strategies to

maximise "trustworthiness". This is always problematical, and perhaps particularly so when a single researcher is involved in analysis. While a number of procedures recommended by Slevin and Sines (2000) were adopted (convergent truthfulness, an audit trail, narrative accounts, providing rich and dense data, multi-site investigation), it was acknowledged that the involvement of others (participants or fellow researchers) in verifying findings may have further enhanced quality. However, given the widespread geography of locations and inaccessibility of researchers at the time of analysis, this would have proved difficult to operationalize.

Finally, the same arguments both supportive and critical, may be made regarding the overall structure governing the literature review (fig. 1.1), the case study method (fig. 2.4) and the cross-case analysis (figs. 3.5 and 3.6). In other words, the identification of different types of variables, embracing different degrees of uniqueness/universality and amenability to change, helped to "make sense" of the breadth and depth of data. Categorization under the four headings (national policy, professional theory, local structures and individual practices) was useful from both methodological and substantive viewpoints, impacting, as it did, on data organization and practice relevance. At the same time, it reflected the compromise between simplification and validity which is surely at the heart of all research.

3.7.4 Implications for future nursing research

The following recommendations arise from the above discussion:

- In view of the nature of theory-building with case study research, replication studies would enhance the external validity of these findings. The use of the concept of case management itself as a "case" to be replicated, using the overall model, with other emergent nursing roles may provide a framework for evaluating practice development.

- The use of a single case design with non-equivalent dependent variables as patterns may be useful for evaluating case management practice within a single site.

- The dissemination of detailed aspects of analytical procedures used in empirical research are desirable for the development of more precise techniques of pattern-matching in case study research. A database of different approaches may facilitate the selection of appropriate techniques in individual research settings.

3.7.5 Conclusions

Although case management has a documented pedigree as a research topic, much of the work, as indicated at the outset (section 1.1.1), emanates from North America, where the concept was conceived. The degree to which this concept, and its contextual determinants, have been replicated in the UK, though not insignificant, has been limited by its re-interpretation in terms of a social and health care policy issue, and by the popularization of a particular model of case management in keeping with those policy reforms. Case management research in the UK has thus also been largely limited to these parameters, leaving a gap in the knowledge base along a number of dimensions. In particular, there has hitherto been little systematic work examining either the role of community nurses in relation to the concept, nor its ability to endure despite radical changes to the social and health care context within which it was originally defined.

This research, it is argued, has made some contribution to fulfilling this knowledge gap by developing some understanding of the complex mechanisms whereby a given way of working may be embraced, operationalized and adapted by community nurses, over various geographical, temporal and specialist domains. This mechanism, it has been suggested, may be conceptualized in terms of a model depicting four influencing contextual variables, which need to be perceived as possessing a high degree of congruence in order to facilitate optimum community nurse case management practices.

Further, it is felt that these conclusions have been largely dependent upon the interpretation and development of the case study method proposed by Yin (1994). The research has taken the method beyond the guidelines appearing in the literature, and its interpretation documented and offered for further discussion and application to future research. Thus both substance and method are interrelated as they move towards new understanding in nursing practice and research.

Appendix I Questionnaire schedule

KING'S COLLEGE LONDON

Department of Nursing Studies

Questionnaire on Initiatives in Community Nursing

SECTION A

Question A1

Please state your job title/designation

Question A2	Question A3
For which of the following services are you responsible? Please ring ALL letters that apply:	For which of the following client groups are you responsible? Please ring ALL letters that apply:
a. District Nursing	a. Elderly
b. Health Visiting	b. Mentally ill
c. Community Psychiatric Nursing	c. People with learning difficulties
d. Community Midwifery	d. Children
e. Community Paediatric Nursing	e. Maternity care
f. Community Nurse Specialists	f. Young disabled
g. All community nursing groups	g. All community nursing groups
h. Other (please specify) _____	h. Other (please specify) _____

Question A4

Please describe below any community nursing involvement in planning for operational policies or standards related to joint working (NHS and Community Care Act, 1990) of which you are aware in your area of responsibility (e.g. working groups, consultation).

SECTION B

We would like to know about any initiative or project (planned, in existence or completed) related to joint working between community nursing and other agencies. The areas we are particularly interested in are outlined below and it would be helpful if you could describe them in the spaces provided.

(If you are involved in, or aware of, more than one project, please describe ONE of them here [preferably the main one you have experience of] and then refer to SECTION C)

Question B1

Please give details of:

a. Which community nursing service(s) are involved

b. The grade(s) and number of nurses involved

c. Any other agencies involved

d. The client group(s) involved

Question B2

Please indicate the functions of nursing and other agencies

	Community Nursing (please tick)	Other agencies (please specify which)
a. Assessment of clients		
b. Negotiating packages of care		
c. Delivering care		
d. Purchasing care		
e. Monitoring care		
f. Budget holding		

Question B3

Please describe any other features of the initiative.

Question B4

Where nurses are involved in the new initiative, please indicate whether this takes up ALL the professional nursing time, or whether nurses also continue in their "conventional" role for some of the time (ring appropriate letter):

a. Nurses involved full-time in initiative

b. Nurses also continue in conventional role

Question B5

What term (if any) is used to describe the new role/way of working adopted by community nurses, as outlined above? (ring appropriate letter):

a. Case manager

b. Care manager

c. Key worker

d. Care co-ordinator

e. Care programme approach

f. Shared care

g. Other (please specify)

_____

Question B6

Please describe briefly, in the space provided, any specific advantages you see as resulting from the initiative. For instance:

* Individualised, needs led, care
* Patient/client advocacy
* Co-ordination of services
* Cost-effectiveness of care delivery
* Quality assurance/maintenance of care standards

Question B7

Please describe any drawbacks for patients/clients or for nurses

Question B8

If the initiative is a special project/pilot scheme please give details of any limits in terms of:

* Time

* Funding

Question B9

Please give details of:

* Any existing or anticipated evaluation of the initiative

* Any plans to extend the initiative in your district (e.g. to a wider area, different client or nursing groups)

SECTION C

Please answer this section only if you are involved in, or aware of, initiatives other than the one described, involving joint working.

For other initiatives, please indicate:

* Community nursing service(s) involved:

* Client group(s) involved:

* Whether you would be able, and willing, to complete another questionnaire relating to the above (please ring letter):

a. Yes

b. No

* Whether (an)other nurse manager(s) would be able, and willing, to complete a questionnaire (if so,please give details)

Thank you for your help. Please return the questionnaire in the prepaid envelope provided.

Appendix IIa Interviewee form relating to ethical issues

INFORMATION FOR COMMUNITY NURSES AND THEIR MANAGERS

Community nursing and Community Care - a study of innovations in practice.

We are nurse researchers from the Department of Nursing Studies, King's College, London, involved in a study which is looking at the impact of Community Care policy on community nursing. In particular we are interested in how this influences practice at a local level and would be grateful if you could spare some time to talk to one of us about the experience in your area. We also hope to interview a sample of patients/clients and their carers with their consent and yours.

The interview should take about 45 minutes - 1 hour and will be arranged at your convenience. It will be tape-recorded with your permission, though the tapes will remain unidentifiable and be erased following data analysis.

All information we receive will remain confidential and you will not be identified in any subsequent documentation. You are also free to withdraw from the study at any time, should you wish to do so.

If you have any questions or require further information, please contact us at any time before the interview at King's College on 071 872 3216/3015.

Thank you for your assistance.

Ann Bergen (Lecturer)
Sara Marshall (Research Assistant)

Appendix IIb Interviewee form relating to ethical issues

INFORMATION FOR CLIENTS AND CARERS.

Community nursing and Community Care - A study of innovations in practice.

We are nurse researchers from the Department of Nursing Studies, King's College, London, involved in a study which is looking at the impact of Community Care policy on nurses working in the community. In particular we are interested in hearing about the experiences of people receiving nursing services and their main lay carers and how any changes might be affecting their care. We would be grateful if you could spare some time to talk to one of us about this.

The interview should take from 45 minutes to an hour and will be arranged at your convenience. It is hoped that we will interview you both seperately because we like to ask you diferent types of questions. This interview will be tape recorded with your permission. The tapes will only be listened to by the researchers involved in the study and will be erased following data analysis.

We would also like to ask you if we could have a look at your nursing notes, which we would arrange with your nurse and in addition discuss with her some details of the care you receive. All these things help us to build a picture of the care in your case.

All information we receive will remain strictly confidential and you will not be identified in any subsequent documentation, nor will what you say influence your care in any way. You are also free to withdraw from the study at any time, should you wish to do so. Whether you participate in the study or not will not affect any care that you will receive. We must emphasise that we are researchers and as such are not able to directly influence the care you receive in any way.

If you have any questions or require further information, please contact us at any time before the interview at King's College, London on 071 872 3216/3015 and we will call you back for a chat.

Thank you for your assistance.

Ann Bergen (Lecturer) Sara Marshall (Research Assistant)

Appendix III Nurse manager interview schedule

INTERVIEW SCHEDULE FOR NURSE MANAGERS

SECTION A

HISTORY OF CC CHANGES IN THE AREA

Q1) Can you briefly describe the current approach to Community Care in this locality?

ii) Have there been any changes in community care in this locality since last April?

Q2) Why do you think this particular approach was taken in this area?

If not mentioned - i) Were there any pilot studies conducted in this area ?

If yes - ii) Do you think this pilot study had any influence on the decisions that were made?

If yes - In what ways do you think it influenced the decisions?

If no - Can you tell me why not?

- How do you feel about this?)

Q3) Were you involved in the decisions regarding these recent changes?

If yes- i) How were you involved? (e.g. working groups; advisory meetings etc.)

ii) Who else was involved?

SECTION B

CURRENT SITUATION

Q4) The Government Community Care reforms advocate a care/case management approach to the delivery of care. Are you using this type of care delivery?

If yes - i) How do you refer to this new type of care delivery?

ii)Who manages this care delivery?

iii)What agency are they from?

iv) Why do you think this agency was chosen?

v) How do you feel about this?

vi)What is their role with regard to;

assessment?

negotiating packages of care?

delivering care?

purchasing care?

monitoring care?

- Are they budget holders?

(If no - Can you tell me why not?

- To what level are the budgets devolved?

- How do you feel about this?)

- What do you think are the advantages or disadvantages of this role?

- Can you give me examples of what you mean?

If no - Can you tell me why not?

- How do you feel about this?

Q5) What is your role with regard to these care managers?

Q6) From your experience what do you think are the advantages of this approach?

For each - Can you give me an example. of what you mean?

Q7) From your experience what do you think are the disadvantages of this approach?

For each - Can you give me an example. of what you mean?

IF COMMUNITY NURSE HAS NOT BEEN MENTIONED PREVIOUSLY ASK;

Q8). What is the role of community nurses within this approach to care delivery that we have discussed, with regard to:

assessment?

negotiating packages of care?

delivering care?

purchasing care?

monitoring care?

- Are they responsible for a budget at all ?
- How do you feel about their current role?

SECTION C

FUTURE PROJECTIONS

Q9). Looking towards the future (i.e. the next 2 years) do you see the role of community nurses changing?

If not mentioned; -Do you think their role will change regarding;

assessment?

negotiating packages of care?

delivering care

budget holding

purchasing care?

monitoring care?

FOR EACH - *If yes* - In what ways?

Can you yell me why ?

How do you feel about this ?

Q10). Will the CNs receive any preparation /training in view of these changes ?

If no - Can you tell me why not?

How do you feel about this?

Q11). What do you consider are the advantages of these future plans?

Q12). What do you consider are the disadvantages of these future plans?

Q13). We have talked in detail about a number of issues. Is there anything you would like to add or you feel is important?

Thank you very much for your help.

Appendix IV Community nurse interview schedule

INTERVIEW SCHEDULE FOR COMMUNITY NURSES

SECTION A

INTRODUCTION

There have been many changes in national community care policy and practice over the past few months. From previous data we have collected, it appears that community nurses' roles are changing with respect to complex cases which require multi-agency intervention.

Q1) You mentioned on the data sheet that you were a key worker/case manager etc. Can you tell me briefly what this means to you?

SECTION B

CASE REFERRAL

I would now like to focus on specific aspects of your role in detail beginning with case referral.

Q2) What is your current caseload i) in total

ii) With regard to case managed clients?

Q3) What proportion of your time is devoted to the case managed group as a whole?

ii) Do you think this is appropriate ?

If yes - Can you tell me why you think this is appropriate?

If no - Can you tell me why you don't think this is appropriate?

- What do you think could be done about this?

Q4) Are you able to take on all eligible referrals for case management immediately?

If no - Can you tell me why not?

- How are decisions made regarding which referrals are accepted immediately?

- How do you feel about this ?

Q5) From what sources do you take referrals ?

ii) Is there a predominant source ?

If yes - Which?

Q6) By which methods are referrals made?

ii) Is there a predominant method?

If yes - Which?

iii) Which is your preferred method?

- Why?

Q7) What are the criteria for referral to you as the case manager (or equivalent title) as opposed to another agency in complex cases?

ii) Is there a screening process prior to referral?

ASSESSMENT

I would now like to focus on the assessment process.

Q8) What needs are you responsible for assessing?
(Probe - health, social or both if necessary)
- Can you tell me why you are responsible for assessing these?

Q9) Are any other professionals involved in assessment? ***(Probe SW,GP,OT)***
If yes - Can you tell me what their role(s) is/are ?
- Do you think this is satisfactory?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

If no - Can you tell me why not?
- Do you think this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

Q10) How do/ would you feel about formally assessing for non-health needs?
- Can you tell me why you feel/ would feel this way?

Q11) How is referral for assessment to other agencies undertaken?
- Is this your responsibility or not?
If no - Whose responsibility is it?
- Do you think this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

Q12) Are any non-professionals involved in the assessment procedure at all? (e.g.. carers, neighbours, home helps etc.)

If yes - Can you tell me why they are involved?
- Can you tell me what their role is?

If no - Can you tell me why not?
- Do you think this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?)

Q13) Where are assessments undertaken?
- Can you tell me why?

Q14) How long do assessments generally take?

- Do you think this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?
I f yes - Can you tell me why?)

Q15) Can you tell me about the format of the assessment schedule?
If necessary probe ;

- Is it a checklist or a biographical approach?
- Is it a joint assessment schedule?
- Why do you think this particular schedule was chosen?

Q16) When was this schedule first implemented?

ii) Who devised this assessment schedule ?
If necessary, probe - Were you involved in its design ?

If no - Who was involved in its design?
- Can you tell me why you think you were not involved?
- Do you think this was satisfactory ?
(If no - Can you tell me why you think not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

If yes - What was your involvement?
- Why do you think you were involved?
- Who else was involved?

Q17) What is formulated / documented at the end of each assessment? (i.e. statement of needs or of services?)

CARE PLANNING

I would now like to focus on the process of care planning.

Q18) How long does it take to plan care after the assessment has been completed?

Q19) Who is involved in planning care?
If necessary probe -What other agencies?
- Is the client and /or their carer involved ?

Q20) Is care planning carried out individually when other services are involved or jointly?
If necessary probe - Can you tell me a little about this process?
- Where does this take place?
- How often does this take place?

Q21) Do you have written care plans?

If no - Do you think that this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?)
If yes - Can you tell me why?)

If yes - What form does this documentation take?
- Where is this kept? - (clients home/files etc.)
- Do you think that this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

ii) Do the other services have written care plans?

Q22) Are you always able to meet client needs ?

If no - Can you tell me why not?

- What do you think could be done about this?

Q23) Are unmet needs recorded at all?

If no - Can you tell me why not?

- Do you think that this is satisfactory?

(If no - Can you tell me why you think not ?

- What do you think could be done about this?)

If yes - Where are they recorded ?

- Do you think that this is satisfactory ?

(If no - Can you tell me why not ?

- What do you think could be done about this?

If yes - Can you tell me why?)

CARE DELIVERY

I would now like to focus briefly on care delivery.

Q24) How are services arranged and secured once they have been decided?

If necessary probe;

- Who is responsible for arranging /securing services?

-Why are they responsible for arranging/securing services?

-Do you think that this is satisfactory?

(If no - Can you tell me why not ?

- What do you think could be done about this?

If yes - Can you tell me why?)

Q25) How long is there in general between care planning and care delivery?

ii) Is this the same with all the services?

Q26) Are you involved in delivering care to clients?

- Who else is involved?
- Do you think that this is satisfactory?

(If no - Can you tell me why not ?

- What do you think could be done about this?

If yes - Can you tell me why?)

ii) ***IF APPROPRIATE*** - Are the SW care mangers involved in delivering care to clients?

Q27) Are you responsible for a budget ?

If no - Who is responsible for the budget for social care/health care?

- What is their background?

(- How do you access this budget?)

Q28) Do you see any advantages of devolving the budget further down to your level ?

Q29) Do you see any disadvantages of devolving the budget further down to your level ?

Q30) Do you think the budget will be devolved to you in the next two years ?

If no - Can you tell me why not?

- How do you feel about this?

If yes - How do you feel about this?

MONITORING AND REVIEW

Q31) Are case reviews carried out?

If no - Can you tell me why not?

- Do you think that this is satisfactory ?

(If no - Can you tell me why not?

- What do you think could be done about this?

If yes - Can you tell me why?)

If yes - What form do the reviews take ?

- Who carries the reviews out?

- Do you think that this is satisfactory?

(If no - Can you tell me why not?

- What do you think could be done about this?

If yes - Can you tell me why?)

ii) Is any informal monitoring carried out?

SECTION C

I would just like to focus now on case X who you have identified as one of your clients for whom you deliver care by the case management/key worker system.

Q32) Focusing on Case X, I would now like to ask a few questions about **referral** in their case:

- From where was X referred to you?
-What method of referral was used?
-Why was X referred to you as opposed to another agency?

Assessment

- For what needs did you assess ?
- Were any other professionals involved in the assessment?
    - If yes - Who were they and what were they assessing for?
        - How were they involved?
- Were any non-professionals involved in the assessment?
    - If yes - Who were they and why were they involved?
-Where was the assessment undertaken?
- How long did the assessment take?
- What assessment schedule was used?
- What needs were identified?
- Were these needs documented anywhere? - if so - In what form?

Care planning

- How long was there between Xs assessment and care planning?
- Who was involved in Xs care planning?
- Was there any documentation of this care planning ?
- Did X have any needs you were unable to meet?

Case review

-Has any form of case review been carried out?
- Can you tell me a bit about this?

SECTION D

Q33) Are the methods of referral, assessment etc. that we have discussed any different from previous methods used (i.e. over the past few years) ?

If yes.- In what ways do you think they are they different?
- Can you give me an example of what you mean?

Q34) Would you describe the current system of working as satisfactory or unsatisfactory?

If satisfactory - Can you tell me why you think it is satisfactory?
-What benefits do you think case X has received from this approach as compared to a more traditional approach?

If unsatisfactory - Can you tell me why you don't think it is satisfactory?
- What do you think could be done about this?
-What drawbacks do you think case X has received from this approach as compared to a more traditional approach?

Q35) Is there any one person who is responsible for co-ordinating all the different processes that we have discussed?

If yes -Who are they?
- What agency are they from?
- Do you think that this is satisfactory ?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

If no - Do you think that this is satisfactory?
(If no - Can you tell me why not ?
- What do you think could be done about this?
If yes - Can you tell me why?)

SECTION E

OTHER ISSUES

I would just like to focus now on several issues which have been prevalent in discussions surrounding Community Care.

If not already discussed in previous responses .

ADVOCACY

Q36) Advocacy has been emphasised within Community Care policy documents.

- What do you understand as client advocacy?
- Can you give me an example of what you mean from your own experience?
- Do you feel advocacy as you have described it is important or not?

If yes - Can you tell me why you think so?

If no - Can you tell me why you don't think so?

ii) Do you feel you are able to be a client advocate under the current system?

If no - Can you tell me why you think not?

- What do you think could be done about this ?

If yes - Can you tell me in what ways you think so?

- Do you think anything more should be done ?

ACCOUNTABILITY

Q37) To whom are you professionally accountable?

(If necessary probe- - Who are you answerable to?)

ii) Are they from the same professional background?

- Do you think that this is satisfactory ?

I f no - Can you tell me why not?

- What do you think could be done about this?

Q38) Do you feel you have adequate professional support in your role ?

If no - Can you tell me why you think you don't ?

- What do you think could be done about this?

If yes - Who gives you this moral and practical support?

-What form does it take?

TRAINING

Q39) Have you had any specific training/preparation for your current role?

If no - Can you tell me why not?

- What do you think you should of had?

- Do you think that you will have this?

(If no - Can you tell me why not?

- What do you think could be done about this?

If yes - What form did this take ?

- How many days did this involve?

- Was this compulsory or voluntary?

- Do you think that this was satisfactory ?

(If no - Can you tell me why not?

- What do you think could be done about this?

If yes - Can you tell me why?)

TEAM WORK

Q40) You've already mentioned that you work closely with other services, how do you relate to.....? If hasn't mentioned SW, GP, OT etc.

Q41) Some projects have experienced conflicts in relationships where they are working closely with other agencies . Have you experienced this?

SECTION F

We have discussed in detail many of the issues surrounding the recent changes in community care.

If appropriate:

Q42) What do you personally consider is the philosophy behind these changes in this locality?

ii) Do you feel then that this is being achieved at present ?

If no - Can you tell me why not?

- What do you think could be done about this?

If yes -- In what ways is this being achieved?

- Do you think more could be done to achieve this?

Q43) We have discussed in detail many aspects of your current role. How do you see your role changing if at all over the next few years?

- Can you tell me in what ways?

- How do you feel about this?

Q44) Do you feel you are getting job satisfaction now?

If no - Can you tell me why not?

- What do you think could be done about this?

If yes - In what ways?

- Do you think anything more could be done about this?

Q45). We have talked in detail about a number of issues. Is there anything you would like to add or you feel is important?

Thank you very much for your help.

Appendix V Client interview schedule

INTERVIEW SCHEDULE FOR CLIENT

SECTION A

BACKGROUND

Firstly I'd like to ask you a few general questions .

Q1). Do you have a member of the family or a friend or neighbour who cares for you?

If necessary-- What is their relationship to you?

- Do they live with you?

If yes - Can you tell me what they do for you on a typical day?

Q2). Have you been admitted to hospital or to a nursing home over the past year?

If yes - Where were you?

- Were you ill or was it for another reason?

If necessary - Can I ask what reason it was for?

- How long were you in there for?
- How long is it since you came home?
- How does being cared for at home compare with being cared for in hospital /institution?
- Can you give me an example of what you mean?

If no - How do you think you would feel about being cared for in a hospital / institution rather than at home?

- Can you tell me why you would think this way?

-What would be the best thing about being cared for in x?

-What would be the worst thing about being cared for in x?

-Can you tell me why you would feel this way?

Q3). You are receiving help/services at the moment. Can you tell me if you were involved in deciding what services/ help you required ?

If yes - How did you feel about being involved in these decisions?
- Who else was involved in deciding what services/help you needed?

If appropriate - - Who did you negotiate with to increase the amount of services you receive?

If no - Why do you think you weren't involved in these decisions?
- How do you feel about this?
- Who was involved in the decisions as to what care you would receive?

SECTION B

SERVICES PROVIDED IN GENERAL

I would now just like to focus on individual aspects of the help you receive from outside agencies:

Q4) What help do you receive with **household chores e.g. shopping, cleaning, cooking etc.?**

FOR EACH SERVICE
- Why do you receive this?
- How long have you been receiving this?
- Who arranged this service for you?
- Who provides this service?
- Do they always come when you are expecting them i.e.when they say they will?
- Do they come when you want them to i.e. at a time convenient to you?

Q5). What help do you receive with **looking after yourself e.g. washing, dressing, feeding mobility, etc.?**

PROBE FOR EACH AS ABOVE

Q6). What help do you receive with your **health needs e.g. dressings, medicines, catheters etc. (probe-nurses, GPs, OTs, physios etc.).**

PROBE FOR EACH AS ABOVE

SECTION C

PROFESSIONAL INVOLVEMENT

Thinking about all the professionals we have discussed who provide help for you;

Q7). Is there any one professional who has overall responsibility for your care?

If yes - Can you tell me who this is?

-How long has s/he been involved in helping you?

- What does s/he do for you ?

- Has what s/he does for you changed within the past year or not?

- How often do you see her/him?

- Is this sufficient ?

- Is s/he easy to get hold of?

(*If no* - Can you tell me why not?

- What do you think could be done about this?)

(*If yes* - How do you contact them?)

IF NO GO TO QUESTION 12.

Q8). Has s/he been useful in;

a) Introducing you to other services? (e.g.. meals on wheels)

- Can you give me an example?

b) Providing treatment?

- Can you give me an example?

c) Providing aids and equipment?

- Can you give me an example?

d) Providing support/ someone to talk to?

- Can you give me an example?

e) Providing information?

- Can you give me an example?

Q9). What benefits do you think there are for you of having Y involved in this way?

- Can you give me an example?

Probes - Has s/he provided you with anything more than you were receiving before ?

- What help do you think is the most useful to you?

-Have you seen any improvement in yourself since s/he became involved ?

Q10). Is there anything you think s/he could do to improve the help you receive or not?

- Can you tell me what?

Probes - Are there any services you feel you need but don't have?

- Are there any services you receive that you feel you don't really require?

Q11). There are often disadvantages when changing to new methods of practice. Do you think there have been any disadvantages since Y became involved in providing help for you?

If yes - Can you tell me what these are?

- What do you think could be done about this?

IF COMMUNITY NURSE HAS BEEN DISCUSSED ABOVE :

Q12). We have talked in detail about a number of issues. Is there anything you would like to add or you feel is important?

Thank you very much for your help.

IF COMMUNITY NURSE HAS NOT BEEN MENTIONED ABOVE ASK;

Q13). Can I just ask you the same questions about Y your CN / CPN?

If yes - Can you tell me who this is?

-How long has s/he been involved in helping you?

- What does s/he do for you ?
- Has what s/he does for you changed within the past year or not?
- How often do you see her/him?
- Is this sufficient ?

(If no - Can you tell me why not?

- What do you think could be done about this?)

- Is s/he easy to get hold of?

(*If no* - Can you tell me why not?

- What do you think could be done about this?)

(*If yes* - How do you contact them?)

Q14). Has s/he been useful in;

a) Introducing you to other services?

- Can you give me an example?

b) Providing treatment?

- Can you give me an example?

c) Providing aids and equipment?

- Can you give me an example?

d) Providing support/ someone to talk to?

- Can you give me an example?

e) Providing information?

- Can you give me an example?

Q15). What benefits do you think there are for you of having Y involved in this way?

- Can you give me an example?

Probes - Has s/he provided you with anything more than you were receiving before ?

- What help do you think is the most useful to you?

-Have you seen any improvement in yourself since s/he became involved ?

Q16). Is there anything you think s/he could do to improve the help you receive or not?

- Can you tell me what?

Probes - Are there any services you feel you need but don't have?

- Are there any services you receive that you feel you don't really require?

Q17). There are often disadvantages when changing to new methods of practice. Do you think there have been any disadvantages since Y became involved in providing help for you?

If yes - Can you tell me what these are?

- What do you think could be done about this?

Q18). We have talked in detail about a number of issues. Is there anything you would like to add or you feel is important?

Thank you very much for your help.

Appendix VI Carer interview schedule

INTERVIEW SCHEDULE FOR CARERS

SECTION A

BACKGROUND

I would just like to start by asking you a few questions about yourself and X if that's alright with you:

Q1). Can you describe what you do on a typical day for X? ***(If necessary probe yesterday, this morning?)***

Q2). How much time does this take up every day/week?

Q3). Has X been admitted to hospital or to an institution over the past year?

If yes - Where were they?
- Were they ill or was it for another reason?
- *If necessary* - Can I ask what reason it was for?
- How long were they in there for?
- How long is it since they came home?
- Were there any opportunities for you to explore alternatives to home care for example residential care ?

Q4). Were you involved in deciding what services/ help X required *(when they came home)* ?

If yes - How did you feel about being involved in these decisions?
- Who else was involved in deciding what services/help you needed?

If no - Why do you think you weren't involved in these decisions?
- How do you feel about this?
- Who was involved in the decisions as to what care X would receive?

SECTION B

SERVICES PROVIDED FOR X

I would just like to focus on some of the services/ help X receives for a moment.

Q5). What help does X receive with **household chores e.g. shopping, cleaning, cooking etc.?**

FOR EACH SERVICE

- Why does X receive this?
- How long have they been receiving this?
- Who arranged this service ?
- Who provides this service?
- Do they always come when you are expecting them i.e.. when they say they will?
- Do they come when you want them to i.e.. at a time convenient to you?

Q6). What help does X receive with **looking after her/himself e.g. washing, dressing, feeding mobility, etc.?**

PROBE FOR EACH SERVICE AS ABOVE

Q7). What help does X receive with **health requirements e.g.dressings, catheter etc.?**

PROBE FOR EACH SERVICE AS ABOVE

SECTION C

PROFESSIONAL INVOLVEMENT

Thinking about all the professionals we have discussed who provide X with help:

Q8). Do any of these professionals have overall responsibility for X's care?

If yes - Can you tell me who this is?

-How long has s/he been involved?

-What does s/he do for X?

- Has what s/he does for X changed over the past year ?

- How often do they see her/him?

- Do you think that this is sufficient ?

- Is s/he easy to get hold of?

IF NO - GO TO QUESTION 13.

Q9). Has s/he been useful in;

a) Introducing X to other services? (e.g. meals on wheels)

- Can you give me an example?

b) Providing treatment?

- Can you give me an example?

c) Providing aids and equipment?

- Can you give me an example?

Q10). Thinking back to when Y started helping X . What benefits do you think there are for X of having Y involved in this way?

- Can you give me an example?

Probes - Has s/he provided X with anything more than they were receiving before ?

- What help do you think is the most useful to X?

-Have you seen any improvement in X since s/he became involved ?

Q11). Is there anything you think s/he could do to improve the care package X receives or not?

- Can you tell me what?

Probes - Are there any services you feel X needs but does not have?

- Are there any services X receives that you feel s/he doesn't really require?

Q12). There are often disadvantages when changing to new methods of practice. Do you think there have been any disadvantages since Y became involved in Xs care ?

If yes - Can you tell me what these are?

- What do you think could be done about this?

IF COMMUNITY NURSE HAS BEEN DISCUSSED ABOVE GO TO QUESTION 18.

IF COMMUNITY NURSE HAS NOT BEEN MENTIONED ABOVE ASK;

Q13). Can I just ask you the same questions about Y your CN / CPN?

-How long has s/he been involved?

-What does s/he do for X?

- Has what s/he does for X changed over the past year ?

- How often do they see her/him?

- Do you think that this is sufficient ?

- Is s/he easy to get hold of?

Q14). Has s/he been useful in;

a) Introducing X to other services? (e.g. meals on wheels)

- Can you give me an example?

b) Providing treatment?

- Can you give me an example?

c) Providing aids and equipment?

- Can you give me an example?

Q15). Thinking back to when Y started helping X . What benefits do you think there are for X of having Y involved in this way?

- Can you give me an example?

Probes - Has s/he provided X with anything more than they were receiving before ?

- What help do you think is the most useful to X?

-Have you seen any improvement in X since s/he became involved ?

Q16). Is there anything you think s/he could do to improve the care package X receives or not?

- Can you tell me what?

Probes - Are there any services you feel X needs but does not have?

- Are there any services X receives that you feel s/he doesn't really require?

Q17). There are often disadvantages when changing to new methods of practice. Do you think there have been any disadvantages since Y became involved in Xs care ?

If yes - Can you tell me what these are?

- What do you think could be done about this?

SECTION D

SERVICES FOR CARER

Just turning and focusing on **you** for a moment.

Q18). Other than the help that we have discussed do **you** receive any help in relation to your caring tasks?

If not already mentioned

RESPITE

Q19). Some carers emphasise their need for respite - Since you have been caring for X have you felt this need for respite?

If Yes - Why do you think that you required respite?
- Was respite care arranged/provided for you?
- Do you think that this was satisfactory?

If CN has not been mentioned in previous answer -Have any respite services been arranged/provided for you by the CN /CPN ?

If no - Why do you think respite care wasn't provided for you?

ii). What features of a respite service are essential for you?

INFORMATION

Q20). Some carers emphasise their need for information . Since you have been caring for X, have you felt this need for information? ***a) services b) Xs condition c) your caring tasks d) financial matters ?***

If Yes - What did you require information about?
- Was this information given to you ?

If yes- Who gave you this information?
- Was this satisfactory ?)

If no - Why do you think was this information not given to you?

If CN has not been mentioned in previous answer:

ii) Is any information provided for you by the CN in terms of a) services b) Xs condition c) your caring tasks d) financial matters ?

MORAL SUPPORT

Q21). Some carers emphasise the need for moral support at times - since you have been caring for X have you needed moral support?

If Yes - Why did you need this?

- Have you been given any moral support?

(*If yes* - -Who provided this?

- Can you describe to me what they did if possible?

- Do you think that this was satisfactory ?

If no - Why do you think moral support wasn't provided for you?

If CN has not been mentioned in previous answer;

ii) Has any moral support been provided for you by the CN ?

If yes - When was this provided?

- Can you describe to me what they did?

- Do you think that this was sufficient ?

SECTION E

Referring back to Y who we were talking about previously :

Q22). What benefits do you think there are for you of having Y involved in this way?

- Can you give me an example?

Probes - Has s/he provided you with anything more than you were receiving before ?

- What help do you think is the most useful to you?

-Have you seen any improvement in yourself since s/he became involved ?

Q23). Is there anything you think s/he could do to improve the help you receive or not?

- Can you tell me what?

Probes - Are there any services you feel you need but don't have?

- Are there any services you receive that you feel you don't really require?

Q24). There are often disadvantages when changing to new methods of practice. Do you think there have been any disadvantages since Y became involved in providing help for you?

If yes - Can you tell me what these are?

- What do you think could be done about this?

Q25). We have talked in detail about a number of issues. Is there anything you would like to add or you feel is important?

Thank you very much for your help.

Appendix VIIa Follow-up questionnaire (original questionnaire recipients and managers, case study sites)

(underlined area variable)

Location: Trust:

Please tick the appropriate box(es) and expand overleaf if necessary.

1. Do you still have community nurses in your area working as case managers?

☐ Yes
Please go to Q.2

☐ No
Please go to Q.3 and continue

☐ Not known
Thank you for your help. Please return questionnaire in prepaid envelope

2. In your area has the number of community nurses in this role over the last 4-5 years:

☐ Expanded?

☐ Remained the same?

☐ Declined?

☐ Not known (eg in post recently)

Please go to Q.4

3. Please give reason(s)

☐ Post(s) discontinued due to change of national/local policy (eg restructuring, funding, end of pilot project)
Please expand if necessary:

☐ Post(s) discontinued as not considered a nursing role (eg taken on by other professionals)
Please expand if necessary:

☐ Post(s) continue(s) but postholder(s) left for personal/individual reasons

☐ Post description and/or title changed
Please expand if necessary and give new title :

☐ Other (*please expand*):

4. In your area do you anticipate the role for community nurses in this capacity is likely to:

☐ Remain as at present?

☐ Expand/be reintroduced?

☐ Decline (if post(s) still in existence)?

☐ Unsure

5. Do you have any other comments you wish to make?
(*Continue overleaf if necessary)*

Thank you for your help. *Please return questionnaire in prepaid envelope*

Appendix VIIb Follow-up questionnaire (case managers)
(underlined areas variable)

Prev. Location: Trust:

Please tick the appropriate box(es) and expand overleaf if necessary.

1. Are you currently working as a case manager?

☐ Yes
Please go to Q.2

☐ No
Please go to Q.3 and continue

2. In your area has the number of learning disability nurses in this role over the last 4-5 years:

☐ Expanded?
☐ Remained the same?
☐ Declined?
☐ Not known
Please go to Q.4

3. Please give reason(s)

☐ Post(s) discontinued due to change of national/local policy (eg restructuring, funding, end of pilot project)
Please expand if necessary:

☐ Post(s) discontinued as not considered a nursing role
Please expand if necessary:

☐ Post(s) continue(s) but postholder(s) left for personal/individual reasons

☐ Post description and/or title changed
Please expand if necessary and give new title :

☐ Other (*please expand*):

4. In your area do you anticipate the role for community nurses in this capacity is likely to:

☐ Remain as at present?
☐ Expand?
☐ Decline?
☐ Unsure

5. Do you have any other comments you wish to make?
(*Continue overleaf if necessary*)

Thank you for your help. *Please return questionnaire in prepaid envelope*

Appendix VIII The case studies: descriptive analysis

The rationale underlying the descriptive analysis was the need not to lose sight of the whole case in focusing upon issues for debate. It was felt there was a need to establish a factual basis prior to theory development, much the same as in the work of Fish et al (1991), who argued for a method of considering professional practice which differentiated events and interpretations, building the latter on the former. This tactic was also suggested by Yin (1994), who referred to the "descriptive data" about the cases. In this research, this covered responses to the main "fact finding" questions on:

- case manager status
- client group characteristics
- features of case management including:
  - referral of clients
  - assessment of needs
  - planning the package
  - care delivery
  - budgetary arrangements
  - review procedures
- management structures
- supervision and support details.

The individual case descriptions in the following tables adopt the logic of the research objectives in terms of headings and are presented largely as an amalgam of the data sources. There was a high degree of convergence in the various lines of enquiry, so that individual respondents are not identified in the limited space provided, although quotation marks are used to indicate less factual data where possible. Incidences of lack of congruence are also highlighted where possible.

A number of points need to be made about abbreviations and terminology adopted in these case presentations:

- The term "case management" is generally adopted in order to standardize respondent and project designations, although the individual's and project's preferred titles, where different, are referred to in the following description and in the direct quotations.

• In the same way "manager" is used to denote the line manager interviewed, as indicated above. The individual's actual title is given under data sources and where this helps clarification of meaning.

• Each case is designated a number, allocated in the main purely on the basis of the order in which it was subject to data collection. Identification of a "case" was on the basis of both the definition given by Yin (1994) and the preset criteria described at section 2.6.4. For most cases this was clear cut, however, case 8 presented a different pattern in its unit of enquiry, in that the three (mental health) case managers in the area each had a separate direct line manager. On these grounds they have been redesignated as separate cases, but labelled 8a, 8b and 8c to indicate linkage in terms of higher management and contact pathways.

• A number of abbreviations and "shorthand" terms have been used as follows:

CN - Community nurse, usually referring to the community nurse case manager respondent

Community care/April 1st 1993 - Used to designate the timing and/or implications of the implementation of the NHS & Community Care Act, 1990.

Care programme approach (CPA)/Section 117 - Terms applying to mental health directives and legislation, as outlined in the literature review.

CPN - Community psychiatric nurse

DN - District nurse

HV - Health visitor

LDN - Learning disability nurse

GP - General practitioner

SW - Social worker

SS - Social services

RDP - Research & Development for Psychiatry (see literature review).

Case 1

Data sources: Manager (area manager, district nursing)
CN (district nurse)
(No client interview. Suitable client died a few days before interview due)
Doc: SS community care documentation

History: Not a lot of change had taken place since 1st April, 1993, since there had been less uptake of care packages than had been expected. Care therefore tended to be constructed in a piecemeal fashion as before. Current practice evolved from a previous pilot study centring on a GP practice.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
District nurse (1), H grade, RGN, DN. Joint secondment, 2/3 time team leader (CN), 1/3 time care manager for SS team, employed by health commission.	Elderly people registered with GP practices (16) to which CN attached. About 8 "big packages" on current caseload. Up to 20 referrals a month.	As adopted by SS, based on social entrepreneurship, advocacy, & user-led services. Also breaking down barriers with SS.	Accountability to team leader (SS), though employed by health commission. Area manager, CN, offered professional advice.	Learned in post. Also learning through community care training days with SS & team meetings. Support mainly from SS staff.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Largely from primary health care team or hospital.	For residential care, respite & "big packages of care at home", but not full community care assessment.	Care plan shared with SS.	Largely purchaser of care and seeing client placed, rather than "hands on" care. But also some talk of service response as logical extension of assessment, though in theory the two were separate.	Held by team manager, SS, but there was easy acess for the CN.	Usually took place at 6 weeks, then handed over for annual review to assistants (usually SS).

Case 2

Data sources: Manager (team manager, joint funded by health and social services).
CN (community nurse, learning disabilities).
Carer (mother, "weekend carer" for daughter in 20s with Downs Syndrome and autism).
(Client unable to be interviewed).
Doc: SSD community care documentation

History: Little actual change had been felt with the advent of community care/case management .

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
Community nurse, learning disabilities (1), G grade with mental health background (RMN). Contracted for 30hrs/week, working 1/3 time on case management	Clients with learning disabilities and mental health needs of a specialist nature. Currently 40 clients on caseload, 30 active and 4 of these case managed.	Adopted a "nursing process approach, similar to keyworking but with less detail and less client contact. Emphasis on better access to services & staying in community	CN accountable to nurse team manager - previously accountable to acting divisional manager for mental health.	Community care training days organized by SS. Currently doing ENB 812 course. No regular supervision due to lack of time, but saw psychiatrist in team occasionally.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Channelled through nurse team manager at weekly meetings and may be followed up by her.	CN responsible for ensuring community care assessment done which triggered off any specialist assessments necessary. Financial assessment usually done by team manager. Nursing model base rather than tick box type.	Usually done in groups with everyone involved. Existing formal plan not thought appropriate so CN used one of her own.	CN still involved in care delivery.	Not equivalent to SS model. Manager held the money and CN could apply.	Discussion of who to be reviewed at weekly meeting. Annual major reviews with informal monitoring where there was therapeutic input. CN emphasized role of carers in this.

Case 3

Data sources: Manager (service director)
CNs (community nurses, learning disabilities x 3. Further one declined)
Carer (father of dependent son in 20s)
(Client met but not interviewed)
Doc: Local LD leaflet on case management.

History: Massive change at organizational level since 1st April, 1993, with closure of large residential accommodation and health handing over to SS as lead agency for learning disabilities. CNs as CMs for about 14 months, SWs longer. A pilot study, not yet evaluated.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CNs, learning disabilities (4), all G grade, RNMH. Additional qualifications RGN (1), RMN (1). Joint funded by health and SS. 70% time case management, 30% CN.	Clients with learning disabilities in "patch". No clear cut criteria for nurse allocation. Caseload about 40-50, all case managed in theory.	The same as that of SS care management with multidisciplinary team approach emphasizing client individuality, choice and alternatives to traditional care.	Joint funding meant dual accountability.	Joint training and supervision, organized by SS, with plans to develop it.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
From a multitude of sources (SS, GPs, health visitors, self). Currently static with few new referrals, all those eligible were taken on. Allocation made at monthly team meeting via team leader (SS).	Global asessment of health, social, skills & need for day services plus now financial. Existing SS checklist form supplemented where specific or specialist assessment necessary	Written care plan formulated, and client received a copy.	Reduction in provider work by CNs. Increase in purchaser role. Difficulty in taking on advocacy role.	CNs purchased care through team manager, SS who held budget.	Review occurred formally once a year, with ongoing financial monitoring.

Case 4

Data sources: Manager (service development officer/locality manager)
CNs (district nurses x 3)
Clients (1. Female, 60s, with rheumatoid arthritis, isolated & dependent. 2. Female, 90s, hospital discharge post fractured femur. 3. Male, 70s, hospital discharge with stroke)
Carers (of 2. husband in 90s & sister. Of 3. wife, 60s, rheumatoid athritis, angina, diabetes).
Doc: SS nursing need assessment form.

History: No dramatic change had occurred in working practices since April 1993, but the health directorate within a whole district (ie acute & community) had become lead agency for community care. Multiagency teams at practice & managerial levels.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
District nurse team leaders (4) acting as keyworkers. All grade H, RGN, DN, CPT with ENB courses. Additional qualifications RM (1), CMB (1). One funded by health to work in hospital	Elderly, where health needs predominate and needing a high input of nursing care, especially terminal care. Caseloads over 100 & CNs stated different figures for keyworking (10 - all).	CNs "unofficial" keyworkers, since SS had to advertise for SW care managers. Emphasis on coordination & advocacy, needs assessment, & meeting needs, including those of carers.	Accountability to self, the UKCC, patients, employer, nurse manager. Did not feel accountable to social services.	Manager said CNs already received a lot of training, but CNs said they had no specific training for changing role but professional managerial support.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
From any source, but more likely to be from hospital than previously.	Traditional holistic, nursing model assessment + Barthel score. CNs may also do specialist assessment for SS on clients for residential care	Plan devised between CNs, other professionals involved, clients & carers and kept in client's home.	CNs involved in care delivery.	Not held individually.	Carried out twice yearly unless there was a need to bring it forward.

Case 5

Data sources: Manager (assistant community liaison manager)
CNs (CPNs x 3)
Client (female, 40s, schizophrenic, living alone, with mental health, medication, housing & financial needs.
(One other client defaulted and one was considered dangerous at time of interview).
Doc: Local CPA policy.

History: Not a great deal of change since April 1993. Pilot study (Henderson, 1990) had been devised in conjunction with SS staff, who were members of the team & some of whom were case managers following similar practices with budgets.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPNs x 4 as care coordinators grades G & F, all RMN, one additionally RGN + ENB & management certs. Worked in multi-disciplinary community mental health team, 1/3 time on care coordination	Clients with chronic mental health problems aged 18-65 years, living alone, prone to relapse, multi-service users & often medication defaulters. About 40-50 on caseloads, 10-15 care coordinated	Linked to both acute care "named nurse" system and to CPA with its categorization of simple & complex needs. Emphasis on one worker responsible for coordin-ating care packages across network of care.	Accountability clearly to care group coordinator who was the manager.	Sessions held on benefits & financial issues but not very comprehensive or specific. Regular clinical supervision occurred as well as peer supervision.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Initially, as CPA, referrals from hospital consultant, Now broader source. No-one yet turned down. Allocation to workers via sector mental health team. No clear criteria.	For all needs - mental, social, physical, financial, gradually building up picture. Unclear whether doc. was shared with SS who sometimes reassess-ed.	Written care plan, compiled with client, was kept in client's file. Ideally, clients being discharged from hospital should already have one, but this was not always the case.	Coordinators involved clinically as well as organizing care. Advocacy, seen in terms of accompanying clients and acting as spokesperson.	Accessed via SS.	Approximately 6 monthly, but difficult to get everyone involved (including client) together.

Case 6

Data sources: Manager (senior nurse manager)
CN (CPN x 1. Further 3 unable to arrange, due to maternity leave, sick leave and moving).
(Carer met but not interviewed as client recently died and carer was upset)
Doc: Spcialist assessment forms and care management documentation.

History: Pilot officially started on 1st April 1993.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPNs (3) starting 2 months before April, aiming to have all G grade CPNs as case managers. Interviewee RMN, RGN, Dip. Comm. Health, CPT, ENB 914.	Elderly, 65+ years requiring entry to residential, nursing or respite care. Total on caseload 35, number case managed, 5 (from existing caseload).	Linked in with CPA (& therefore hospital) Emphasis on targeting vulnerable clients, helping people through services & acting as advocate. Independent practitioners, rather than teams, linking with agencies.	Accountability was to the manager.	Training over 3 days for all case managers jointly organized by health & SS. Input on finances & benefits. Further education planned. Prof. support from manager limited but 2 H grade supervisory posts planned

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
So far clients taken from existing caseload. With new clients, person who knew person best would be case manager (SS, DN, HV, CPN & soon LDN). Only difficult cases taken on.	Shared agency approach, different professionals designing form. Assessments essentially for people entering residential/nursing accommodation. Inc. financial assessment.	CN responsible for drawing up the plan as case manager. A copy was provided for clients/carers and one for service provider(s).	This consisted primarily of successful placement. Also continued support, nursing advice & advocacy to clients/carers, especially if in residential home.	Allocated by the care plan forum into subgroup specialties.	Took place 4 weeks after placement, when CN met client, carers, & provider. Following this, review was 3 monthly.

Case 7

Data sources: Manager (nurse manager/care group manager).
CN (CPN/intensive community support specialist).
(Client interview arranged twice but client defaulted).
Doc: Case management assessment forms.

History: No striking changes since 1st April 1993, but developments had straddled, and linked to, community care policy of hospital closure, which had affected area markedly. Pilot developed from 3 year RDP funded project with 7 case managers, in intensive community support team led by SW team leader.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPN (1), G grade, RMN, Dip. Counselling, ENB Cert. Working with 1 SW case manager.	Long term mentally ill. Criteria broadened after pilot. The 15 clients on caseload retained but CN also covered for 2 colleagues' caseloads at time of interview.	Emphasis on working with other agencies, especially SS at operational level & involving users & carers. "Working without barriers across services...acting as extension of patient's family" & advocacy.	Accountability now to manager. During project, CN responsible for day to day matters to colleagues in team & to SW team leader and only for professional (nursing) issues to manager.	Comprehensive training originally provided by research team. CN also member of national demonstration centre with personal interest in specialty. Now support mainly from colleagues & a little from manager.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Originally clients transferred from existing caseloads & allocated by team leader according to protocol. Now from any source & all so far taken on.	For all (social & health) needs. Ten areas identified with client on form based on strengths . Other forms used for specialist areas.	Written care plan kept in the office with record on computer system. Not in form of "nursing process" care plan as this was felt to be restrictive.	Professionals stated importance of case managers providing care.	Nominal budget for all clients held by team during project & now held by manager. Still able to access monies from SS as in project	Carried out at least 6 monthly, but in practice more likely to be 2 monthly, as this tied in with care programme review.

Case 8a

Data sources: Manager (team leader, admin. background)
CN (CPN)
Client (Female, 30s, chronic mental health problems, post hospital discharge, lives with husband & son).
Doc: Psychiatric assessment form and community care assessment for mental health form.

History: No district wide set-up & each area differed. Here impetus from legislation with statutory requirement for community care assessments. Multidisciplinary team set up 3 years previously. Social assessment however predated the legislation & designation of community care assessors merely formalized this.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPN (1) G grade, RMN only case manager in locality working in multidisciplinary community mental health team.	Team dealt with clients with acute & long term mental health problems, though case management focus was on those requiring rehab. after hospital discharge. Currently 45 on caseload, all case managed.	Core phases of case management, emphasizing holistic approach, but drawing eclectically from different models. CN stressed care coordinator & managerial functions.	Accountability primarily to clients & to manager/team leader. Professional hierarchy in place at arms length. Clinical accountability to consultant psychiatrist, psychotherapist & SW.	No formal training for role - "I read up myself". Support mainly from manager/team leader. CN uncertain whether more specific (nursing) support needed. "I don't feel like a nurse any longer..".

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Via weekly team meetings. CN not taking on new referrals since most clients in target group already engaged into service.	Holistic assessment using SS community care form. Other members of team brought in as necessary. New form being introduced for specialist assessment.	Care plan kept in case notes & being put on computer. Clients entitled to a copy but generally did not wish for this.	Manager felt case management not about giving care but CN often involved therapeutically.	Held centrally but some devolution anticipated.	Team meetings held weekly with rolling programme of individual client reviews. May link in with formal section 117 reviews, held 3 monthly.

Case 8b

Data sources: Manager (clinical team leader, also carrying clinical caseload)
CN (CPN)
(Unable to find suitable client)

History: No pilot as such. National policy reflected in district wide philosophy.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPN (1) G grade, RMN studying for MA, in multidisciplinary community psychiatric team of case managers. Co-worked with hospital consultant psychiatrist.	Those with acute & enduring psychiatric problems (ie focus on morbidity rather than mental health). Total on CN's caseload about 40, about 30 case managed. CN specialized in relapse prevention.	Keyworking with a focus on client-led, process approach. Terminology not refined (case, care, keyworking). Targeting & proactive approach, separation of assessment & provision tasks, though could be embodied in same person.	CN saw accountability to manager, primarily, with clinical accountability to consultant psychiatrist & ward team.	All staff attended 3 days training with SS when developing community care assessment & more training planned. CN doing MA independently & picked up ideas from research, conferences etc. Clinical supervision from more experienced CPN.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Mainly from acute psychiatric unit & CN tried to take on all appropriate ones. Criteria for allocation "unspoken rules". CN tended to acquire those prone to relapse.	Formal assessment considered reductionist and CN devised own form for tracing events likely to precipitate relapse. New form to be adopted.	Formal care plan emerged as result of community care assessment under section 117. Otherwise, no plan in "nursing process" format as thought to be restrictive.	CN retained a therapeutic role. Advocacy involved taking on client's responsibilities eg bills.	Manager was budget manager, though his line manager held budget.	Tended to be 6 monthly. Under section 117 reviews a legal requirement, otherwise it was "as and when" at team meetings.

Case 8c

Data sources: Manager (team leader, background in business)
CN (CPN)
Client (male, 20s, schizophrenic, hospital discharge, living independently but supported by parents. Has voluntary job
Carer (mother) present at interview
Doc: Mental health team service guide.

History: No hospital closure in locality to influence change. SWs came from 2 areas, crossing SS borders & in only one of these were all professionals designated assessors. Pilot survey 4 years previously identified specific local needs. Community care did not entail vast changes, but meant CNs working more independently/appropriately.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPN G grade, RMN, Cert Ed doing BSc working in multidisciplinary team in mental health resource centre - all adopting keyworking role.	Team dealt with clients with acute and enduring mental health problems, prioritizing latter. 30-35 on caseload, about 25 case managed.	From models elsewhere & literature. Called keyworkers as CNs reluctant to adopt case management terminology. Emphasis on normalization & close links with community.	CN saw accountability as primarily to himself, since he worked autonomously. Also some accountability to manager, patients, nurse line manager, consultant & GP.	Joint training (health & SS) for community care. Benefits training & more specific health input. CN doing own degree. Some training for, & practice in, supervision.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
Mainly from hospital or GPs. Criteria depended on client needs, size of caseload etc. Waiting list not needed yet & most eligible picked up.	General assessment, structured form covering most areas & other professionals drawn in. Further symptom checklists for depression also used.	Plan agreed with client and sent to GP and anyone else involved.	CN involved therapeutically in rehabilitation & giving neuroleptics, as well as acting in a brokerage capacity.	Manager's own line manager held budget - some talk of further devolution to team leader. Access through management structure, assessment or networking.	Conducted at team meetings or in annual review with consultant. In situations involving family therapy, the family called the review meeting.

Case 9

Data sources: Manager (nurse manager)
CNs (district nurses x 2)
Client (female, 80s, widowed, paraplegic, lives alone, daughter visits).
Doc: Code of practice for combined home care and CN service.

History: To manager, initiative developed from SS designation as lead agency in community care and DNs feeling threatened by inroads made by home carers. This gave rise to idea that nurses should manage these workers, control nursing domains and retain nursing identity rather than have responsibility for social needs & case management. To the CNs community care meant they were able to relinquish certain non-nursing tasks.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
District nurses G (1) and H (1) grade, both RGN, DN, one additionally CPT, SCM, other ENB Cert. Dip. Community Health studies. Worked in nursing team.	Anyone referred but principally elderly disabled. No differen-tiation between case managed and other clients on caseload of about 80-90.	To CNs case managing meant little more than conventional district nursing role, with emphasis on assessment & coordination of care, and referring on to SS.	Accountability to nurse manager, who was a health visitor.	One CN described no preparation but thought attitude & experience important. The other mentioned guidance booklets on community care. Support lacking.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
All referrals accepted. Mainly from hospital or GPs, also SS and self. Allocation at daily "service choice" meetings of all professionals. No explicit criteria used.	Purported holistic assessment including social & financial needs, despite policy that social assess-ments be undertaken by SS. Nursing assessment adopted a nursing process format not shared.	Care plan was formulated and kept with client, with minimal details housed at clinic/base.	CNs involved in care delivery. Though in theory role moving to assessment only, shortage of staff and suitable skill mix prohibited this. Anything outside nursing remit SS responsible for.	Nurse manager held budget and CNs not informed of costings. However, they were aware of a need for extra resourcing.	All patients reassessed every few weeks and 6-12 monthly in a more formal way. No mechanism for feedback to multi-disciplinary forum unless there were difficulties.

Case 10

Data sources: Manager (team leader CPN)
CNs (CPN care managers x 3)
Client (male, 30s, Indian, schizophrenic, lives with 2 brothers, their children and mother).
Doc: Community mental health centre assessment form.

History: System dated back to SWOT analysis 3 years previously identifying long term mentally ill as being overlooked & therefore to be targeted. Community care officially local authority led.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
CPNs x 5 with SS in multidisciplinary community mental illness team, all G grade RMN, CPN. Other qualifications RGN (1), CPT, ENB certs (1) , one doing MSc.	Mentally ill. Numbers on caseloads about 30-40 but of different dependency levels, as clients were not discharged. They were trying to get the numbers down.	Health & SS worked together carrying out same roles. Both purchaser & provider functions with emphasis on client focus. Change very much "from the ground up".	Professional accountability to team leader, though one CN also acknowledged accountability to himself and the professional body.	2 days of "pretty light" joint training with SS. Several less formal meetings with SW counterparts & day on team building. Supervision on 3 monthly rota. Also peer support.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
To team's weekly meeting. No set criteria for allocation - included special interests etc - and not discipline specific. Referrals from variety of sources. Not all eligible taken on.	Not always carried out by care manager. Structured format used by both disciplines, covering 4 major areas inc. finance which was new but CNs gaining confidence.	A written care plan was compiled by care manager and kept in the office.	CNs retained a therapeutic role especially with "high input" clients as did SS care managers. This seen as nursing role & there were few alternatives. Some use of support workers.	Locality manager (mental health) held budget & SW team coordinator signed for provision purchased - still by block contracts, though change coming. CNs could directly refer for this	Carried out 3 monthly & integrated with system of clinical supervision. Thus manager as well as CNs had knowledge of individual clients. Matrix score reassessed at review.

Case 11

Data sources: Manager (nurse team leader)
CN (community nurse, learning disabilities)
Carer (mother, 40s, of male, 20s, with profound handicap & physical disabilities)
(Client too disabled to be interviewed).
Doc: CN as case manager evaluation report.

History: System originated in joint discussion with SS & others in health care about moving to a needs led approach to care. Although change was affected by community care legislation & recent closure of long stay hospital, relations between LD nursing and SS had always been good.

General features:

Case manager status	Client group & caseload	Model of case management	Management issues	Preparation & support
LDN x 1 G grade, RNMH, Cert community Health Care + qualified accountant. Only remaining of 3 nurse care mangers in multi-disciplinary team in area where SWs usually case managers.	People with learning disabilities. Total caseload of 78 included those of 2 colleagues who had left. There were 16 requiring complex packages targeted for care management which took up 80% of time.	CNs were approved care managers in certain cases and called upon by SS for specialist health assessment in others. Used a process approach, much akin to nursing practice. Also advocacy & coordinating services.	Professional acountability to line manager (nurse team leader) & also to the team & SS supervisor.	Good preparation for SS care managers, but not so good for health personnel. Supervision offered by team leaders plus system of peer support.

Case management tasks and processes:

Referral	Assessment	Planning	Care delivery	Budget	Review
From closed hospital & GPs to weekly SS led meeting, allocated by urgency. CNs care managers where health needs predominate.	SS operated 2 level assessment. CNs used complex level as care managers. Included financial element. Also had health assessment using nursing model.	Care plan was formulated by CN & countersigned by team leader (where there were financial implications), client & carer.	CN may provide care for care managed patients where appropriate, but care management mainly a purchaser role.	Accessed by team leader in SS.	Changing from single profession, system led, to more coordinated. 2 monthly reviews, though provider nursing plan reviews continued informally

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